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SAMANTHA COLE BSc Hons, MSc

MANAGEMENT OF CLIENTS WHO SELF-HARM IN UK SECURE FORENSIC UNITS

Section A

Approaches to Managing Clients who Self-Harm in Secure Forensic Wards: A Literature Review

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Section B

The Management of Self-Harming Clients in UK Secure and Forensic Wards: A Delphi Method

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A thesis submitted in partial fulfilment of the requirements of
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Thank you to all the clients I have met whilst training, and before, for reminding me why I needed to stick at this.

To my parents, for their support over the years in helping me pursue my goal to be a Clinical Psychologist.

And to Kirsty.

Summary Section A

Section A presents a systematic literature review exploring management of self-harm on low, medium and high secure forensic wards, including the views and attitudes held by staff regarding clients who self-harm. Papers were reviewed and critiqued in line with two research questions, and then summarised in relation to these questions. Studies were dominated by female populations, and lacked scientifically robust design and methodology. Future avenues of research were considered.

Summary Section B

Section B presented a study explaining the ways in which self-harm is managed in low, medium and high secure forensic wards using a Delphi survey. Surveys explored frequency of management strategies, perceived helpfulness of these approaches, and staff understanding of self-harm. Physical approaches of management were used most frequently, followed by relational and procedural practices. Staff showed strong consensus for self-harm being understood as a reaction to extreme distress or as a communication of their difficult feelings. Models of psychological intervention used with clients were also explored. The limitations of the study were discussed, along with potential future areas of research.

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MANAGEMENT OF CLIENTS WHO SELF-HARM IN UK SECURE FORENSIC UNITS

Section A

Approaches to Managing Clients who Self-Harm in Secure Forensic Wards: A Literature Review
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Abstract

A systematic search of the literature was conducted to firstly explore the evidence addressing how clients who self-harm in secure forensic wards are managed, and secondly what views and understanding of self-harm are held by staff within these wards.

Secure forensic inpatient wards experience the highest rates of self-harm across UK psychiatric services (Walsh, 2009), and face significant challenges in balancing the safety and psychological wellbeing of clients who self-harm.

Guidelines in place to manage individuals who self-harm (NICE, 2004; 2012) are felt to relate poorly to secure forensic services, and due to a dearth of literature exploring the phenomenon within these services, policy guidelines remain under-informed by evidence from forensic services. Papers in this review span different areas of management including risk assessment, staff attitudes, specific model approaches to managing self-harm and narratives on the psychological approach of forensic services.

Each question posed for the review is addressed in turn, and the review concludes with a discussion of the evidence presented, together with areas for potential future research avenues.

The papers reviewed provide a limited view of the management of self-harm in forensic services, mostly utilising small sample sizes and diagnostic categories. Although various management approaches are explored, these appear difficult to generalise across forensic inpatient wards.

Keywords: self-harm, forensic, management, staff attitudes, secure-services

Introduction

Defining Self Harm

Definitions of self-harm vary significantly across the literature. In the 2012 NICE guidelines (Self harm in the over 8's: Longer Term Management) self-harm is referred to as:

“...any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This commonly involves self-poisoning with medication or self-injury by cutting. There are several important exclusions that this term is not intended to cover. These include harm to the self arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself”. (NICE, 2004, p.11).

Definitions of self-harm also vary in their conceptualisation of suicidal intent, and many aim to define self-harm as an act which is separate to a desire to end one's life: 'The deliberate destruction or alteration of one's body tissue without conscious suicidal intent' (Favazza, 1996. See also Herperz , 1995; and Muehlenkamp, 2005). Such definitions perhaps serve more to explain self-harm as a means of coping with distress, and hence are useful in how individual's self-harm, what is being communicated and how to manage this communication.

Providing care and management to individuals who engage in self-harming behaviours is an ever present challenge faced by staff in mental health services,

particularly so within secure and forensic inpatient services (SAFS) across the United Kingdom (UK) (Walsh, 2009; Brooker, Flynn & Fox, 2010). Little research has been conducted specifically considering the challenges of managing self-harm in adult SAFS, as research into this client group tends to focus upon the management of interpersonal violence and aggression (Sarkar, 2011), or areas which carry more public interest, such as decreasing rates of recidivism (Fitzpatrick et al., 2010). Secure forensic services face the unique role of providing treatment and assessment to individuals who have an offending history, as well as providing advice to court and tribunals around issues such as capacity, long-term care requirements and potential suitability of community placements for their clients (Mullen, 2000).

Examining the costs of treatment for self-harm injuries between 1994 and 1995 in a high secure hospital, Swinton and Smith (1997) cite a figure of £227,000, an estimate which was felt to be a gross underestimate (Low, Jones, Duggan, MacLeod & Power, 2001) and given the steady increase seen in rates of self-harm in secure services since this study (Bower, 2012), the cost of managing self-harm in modern day secure forensic NHS wards is likely to be profound. Biases towards the arena in which the phenomenon of self-harm is explored appear to exist, often involving only female population groups (Klonsky, 2007), adolescent groups (Nock & Prinstein, 2004) or outpatient, A&E or community samples (Brown, Comtois & Linehan, 2002).

The National Institute for Clinical Excellence (NICE) have produced two policy guidelines for the management of self-harm within the NHS, firstly in 2004 (Self-harm in over 8s: short-term management and prevention of recurrence, NICE,

2004) and more recently guidelines were published which aimed to make recommendations for longer term management (Self-harm in the over 8's: long term management, NICE, 2012). Sarkar and Beeley (2011) argue these guidelines overlook the "treatment-refusing, potentially hostile" forensic client group, and a Royal College of Psychiatrists monograph (Self-harm, suicide and risk: Helping people who self-harm, 2010) adds that only one in over one hundred studies for the 2004 guidelines draws evidence from a forensic population.

Clinical Practice Recommendations for Psychosocial self-harm Management	Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm.
	<p>The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements.</p> <p>Therapists should be trained and supervised in the therapy they are offering to people who self-harm</p> <p>Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.</p>
Clinical Practice Recommendations for Harm Minimisation	If stopping self-harm is unrealistic in the short term: consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm.
	<p>Consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team.</p> <p>Advise the service user that there is no safe way to self-poison.</p>

Figure 1: NICE (2012) recommendations for longer term management of self-harm

Psychosocial recommendations and harm minimisation strategies are outlined by NICE (2012). Particular models of intervention are not specified. Harm minimisation is advocated for, however it is argued that within secure services, it is unclear how this approach would be managed given the risk averse environments in wards. Sarkar and Beeley (2011) argue that the threefold complexity of managing clients in secure services (i.e. the secrecy of the act, higher rate of physical injury of act and increased likelihood of assaults towards staff) make such guidelines “disappointingly inconclusive” for forensic wards (Tantam & Huband, 2009).

Self-Harm in Secure and Forensic Mental Health Services

In the UK rates of self-harm are highest within secure hospitals and prisons (Walsh, 2009) Favazza (1998) described SAFS as a “hot beds” for deliberate self-harm, and environments whereby the care and management of self-harming clients is most challenging due to factors such as increased aggression towards staff, high staff turn-over and strictly controlled ward environment(Walsh, 2009). Historically, research suggested that women were significantly more likely to self-harm than males however a review by James, Bowers & Van Der Merwe (2011) demonstrated that there is no significant relationship between gender and self-harm. With this in mind, however, it is suggested that of this forensic population, women are more likely to self-harm in the absence of suicidal intent than men (Bland, Mezey & Dolan, 1999 cite that 94% of women studied in high secure forensic wards engaged in self-harm). Uppal (2009) studied incident data from Rampton high secure hospital and found that of 1749 incidents over a 16 month period, 31% related to self-harm, with a significant proportion carried out by women (percentage not specified).

There is a strong association between the act of self-harm and psychiatric diagnosis, and it has been estimated that up to 90 percent of individuals who self-harm will meet criteria for psychiatric disorder (Haw, Hawton, Houston & Townsend, 2001). It is estimated that between 60 and 70 percent of the population of prison and secure services will have a meet diagnostic criteria for personality disorder (National Offender Management Services, 2011). Secure wards also work with a higher proportion of individual's with a diagnosis of Schizophrenia, for whom rates of self-harm are proportionally higher than other populations (Haw, Hawton, Sutton, Sinclair & Deeks, 2005).

Secure Forensic Wards

Forensic mental healthcare involves “*treatment and rehabilitation of mentally disordered individuals who also exhibit a degree of criminality....more often than not involving placement in some sort of secure institution*” (McKeown et al. 2007).

Secure units across the UK consist of low, medium and high wards, reflecting the level of security required in an individual's care. Secure forensic wards are under greater scrutiny to maintain and adhere to stringent security requirements than other mental health wards. Individuals entering the care of SAFS do so because they have, in almost all cases, committed what is deemed to be a ‘criminal act’, most often causing harm to another person or to property, and are hence considered to be of risk to others, or to themselves.

Secure forensic services conceptualise security across three domains; relational, procedural and physical security as outline by the Royal College of

Psychiatrists ‘Standards for Low Secure’ (RCP; 2012) and ‘Standards for Medium Secure’ (RCP; 2012). These guidelines provide specific standards to be met for low and medium secure units, covering all aspects of patient care and general ‘ward life’. These range from identifying staff training needs (relational security) to the height of perimeter fences (physical security) and the need for unit-specific policies on clients absconding (procedural security). See Appendix A for further examples of security requirements. These requirements are steadfast in the provision of secure forensic care, and hence the approach to management of issues such as self-harm, are couched in the pre-existing standards of security which must be met. Writing about the development of a medium secure service for women, which involved emphasis on the underlying difficulties clients experienced with self-harm, Lawday (2009) describes how the organisational structure of secure wards can be experienced as oppressive and result in the ‘re-traumatisation’ of clients. An albeit unintentional recapitulation of traumatic experiences can be embedded in security-focused organisational procedures on forensic wards, such as restraint procedures, staff observation, physical examination, enforced taking of medication and systemic processes such as an absence of choice and control (Lawday, 2009).

Staff attitude towards clients who self-harm

Evidence shows that how staff members view and understand self-harm will shape their approach to managing the client (Gough, 2005; Dickinson, Wright & Harrison, 2009), will affect client outcome (Pompili & Girardi, 2005) and that negative conceptions of self-harm are commonplace (Sandy & Shaw, 2012). Motivations cited for self-harming clients often include terms such as “attention

seeking” or “manipulative” (Dickinson & Hurley, 2009). It is suggested that these terms are borne of a misunderstanding of what is being communicated by the client in the act of self-harm, which increases the likelihood for punitive management approaches towards the client (Beasley, 1999). Exploring the role of the Attribution Theory (Fiske & Taylor, 1991), Wheatley & Austin Payne (2009) found that meaning attributed to the act of self-harm, the degree of perceived control the client has, general knowledge of self-harm and the staff member’s confidence in their ability to help the client all shape the way in which staff manage this client group.

Theories of Self-Harm

Theoretical understanding of the act of self-harm is far ranging and diverse, both in its pragmatic underpinnings and positioning regarding the meaning and communication of the act. Motz (2009) argues that self-harm can be an expression of hope: referencing Winnicott’s (1956) argument of ‘hope in the antisocial act’. Motz (2009) describes self-harm as an attack on the boundary (represented by the body) as a means to test the resilience of the object, to practice pain and destruction but to survive and ultimately withstand the attack.

Scanlon and Adlam (2009) conceptualise self-harm as an act which allows the person to express an element of their internal world which cannot be communicated by other means. The impact of the act of self-harm on those around the individual, particularly those within a caring capacity also forms the basis of some author’s

beliefs around the purpose of the act. Campbell and Hale (1991) describes the ‘attack on the minds of others’ the act of self-harm can have, and the debilitation that can ensue in others who, fearing death as the desired outcome, try to prevent the act of self-harm at all costs. This ‘attack’ on others speaks again to the relational component of self-harm, and how if the early relationship has been fraught with trauma, abuse or neglect, a person will continue to attack future relationships as a way to avoid the feared experience of further pain.

The notion of reciprocal violence underpins some theories of self-harm; Daffern and Howells (2009) hypothesise that that self-harm in secure services is significantly elevated as it serves to replace the aggression that was externalised within the community, prior to detention. Mannion (2009) identified conflict on the ward as the most significant antecedent for self-harm on a high secure unit, adding to the debate for its underpinnings in the internalised focus of aggression.

The relational context of self-harm is present in all theories, either addressing the relationship between self and body, self and other, or both. As Adshead (1998) notes, it is the attachment experience which underpins all acts of self-harm. What remains pertinent, then, within the context of managing self-harm, is how staff relate to individuals who harm themselves.

Self-harm as a means to regulate distressing emotions is proposed by Favazza (1992) who argues that the pain induced by self-harming can provide a degree of perceived stability and regulation within the body; a degree of affect-regulation that some individuals are not able to create using other means, often due to adverse or neglectful early life parental relationships. Gunderson (1984) argues that self-harm

plays an important role in preventing dissociation or depersonalisation in the individual, as the painful act, or the sight of the wound ‘shocks’ the individual into more conscious awareness, and prevents the distressing experience of dissociation.

The role of self-harm as a prevention of suicide is also acknowledged within the literature, whereby the act itself prevents further damage which may have resulted in death. Suyemoto (1998) posits that self-harm can communicate the distress and strength of desire to end one’s life, without causing significant enough harm as to end the person’s life. Others have also theorised that the act of self-harm can ‘stave-off’ suicidal thoughts and actions, acting as a type of ‘release valve’ to prevent the unmanageable build up of distress which might result in more significant harm being carried out (Himber, 1994).

Klonsky (2007) provides an excellent review of theories of self-harm from empirical studies, including 18 papers exploring the functions of self-harm, including; affect regulation, anti-dissociation, anti-suicide, interpersonal boundaries (self-harm as an act to mark a boundary between self and other), interpersonal-influence (to seek help from others), self-punishment and sensation seeking. Klonsky’s (2007) review found of the research reviewed, affect regulation was the primary motive for the act of self-harm, as negative affect was most commonly noted in the literature prior to self-harm incidents, and decrease in this negative affect was most frequently cited as a result of an occurrence of self-harm. The review was also felt to demonstrate a strong link with the self-punishment function of self-harm, along with moderate support for anti-dissociation, anti-suicide, sensation-seeking and interpersonal boundaries.

Consideration of the above theories and functions of self-harm is thus central to considering which management approaches are most useful in caring for people in secure wards, particularly given the higher rate of psychiatric diagnosis within this population associated with affective difficulties, such as borderline personality disorder or psychosis-type diagnoses.

Aims

This review aims to examine the literature describing to how clients who self-harm are cared for and managed within low, medium and high secure forensic wards, alongside how clients who self harm are viewed and worked with by SAFS staff.

A systematic literature search was conducted to answer the following research questions:

1. What approaches for directly working with clients who self-harm in UK forensic wards are presented in the literature?
2. In what ways do secure and forensic staff view clients who self-harm, and what is their understanding of how to work with these individuals?

Method

Search Terms

For a systematic search of the available literature, numerous terms for self harm were identified, including 'self harm', 'deliberate self harm', 'self mutilation', and 'self injurious behaviour'. These were selected with the 'OR' command. Searches were then made for 'forensic', 'secure', 'inpatient', 'high secure', 'low secure', 'medium secure' also including the 'OR' command. A further search was made for, 'staff views', 'staff experience'. The above searches were combined with the 'AND' command. A systematic search was conducted using PsycInfo, ASSIA (Applied Social Sciences Index and Abstracts), EMBASE and Google Scholar. Search dates ranged from the year 2000 to December 2015. Papers selected for inclusion had all reference lists checked for relevant papers (see figure 2).

Inclusion Criteria

Inclusion criteria were also follows:

- I. Studies available in the English language
- II. Studies examining/providing commentaries, strategies, interventions and staff experiences or relevant clinical implications of managing self-harm within adult UK low, medium or high secure forensic wards.
- III. Due to the predicted limited number of relevant papers in the area, specific designs and methodologies were not stipulated within inclusion criteria.

Exclusion Criteria:

- i. Papers not explicitly stating the inclusion of practices reflecting UK low, medium or high secure wards.
- ii. Papers published prior to the year 2000.
- iii. Papers for which management of self-harm is not the significant emphasis of the paper (e.g. is bracketed in with anger management work)
- iv. Papers focusing exclusively on the frequency and description of self-harm acts
- v. Papers addressing a learning disabilities client group, as pathways of care for this population differs from general adult forensic population.

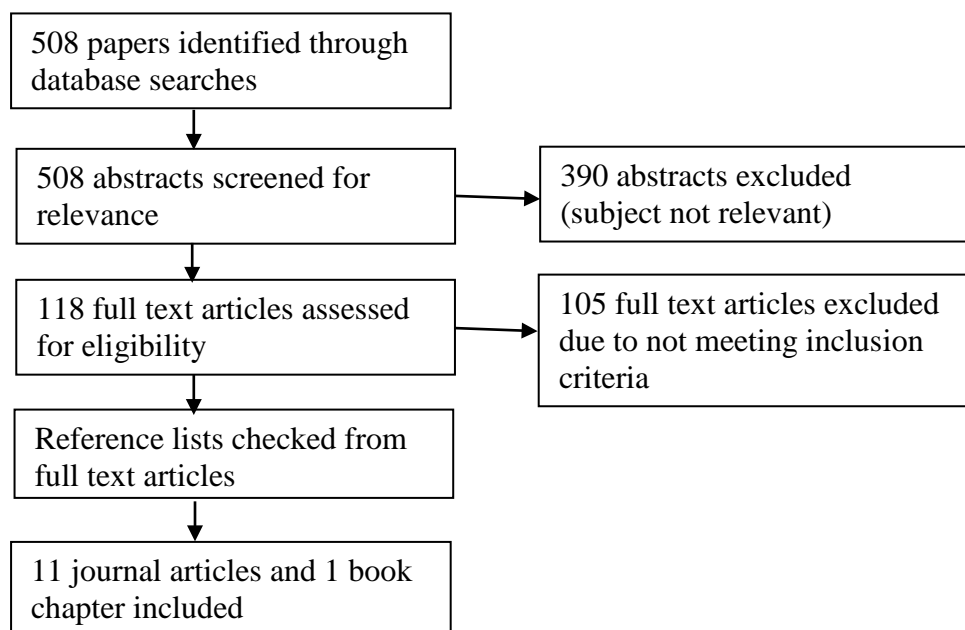


Figure 2. Flowchart of papers included from systematic review

This process yielded 12 peer reviewed journal articles. One book chapter, classified as ‘grey literature’ was included within this review- as this was cited in two of the included papers. Further searches for book chapters not referenced in the

included literature was not conducted. Given the direct relevance of this writing to the research question, it was deemed appropriate to include these with the review.

For qualitative studies and cohort studies in this selection the Critical Skills Appraisal Programme (CASP) was used to assess the merit of the study (see appendix B).

List of articles from Systematic Search-

Author	Title	Year	Setting(s) and Sample	Study Design	Key Findings
1. Gough, K 2. Hawkins, A	Staff attitudes to self-harm and its management in a forensic psychiatric service	2000	Forensic hospital/ secure service	Cohort study; Staff survey.	Highly mixed results across staff members, most indicating desire for specific training on management of self-harm. Staff feel torn between restrictive and permissive approaches to managing self-harm.
1. Low, G 2. Jones, D 3. Duggan, C	The treatment of deliberate self-harm in Borderline Personality Disorder using Dialectical Behaviour Therapy: A pilot study in a high security hospital	2001	High Secure forensic hospital. Women only (n=10).	Pilot and evaluation of efficacy of DBT intervention for women currently self-harming using incident report data and various psychological measures.	Those receiving DBT showed a reduction in rates of self-harm and improvement on psychological measures post treatment, including reduction in dissociation scores and an increase in scores measuring coping and survival beliefs. Significant improvements were also found for depression, impulsiveness and suicidal ideation.
1. Low, G 2. Jones, D 3. Duggan, C 4. MacLeod, A 5. Power, M	Dialectical Behaviour Therapy as a treatment for deliberate self-harm: Case studies from a high security psychiatric hospital	2001	High secure forensic hospital. Women only (n=3).	Case study presentation of three female clients having received DBT for self-harming behaviours over a 12-month period.	Case studies illustrate what individual women have found useful about DBT, specifically in the context of decreasing incidents of self-harm. All three cases saw a decrease in self-harm, and two clients included had moved to lower security units. Particularly useful strategies were suggested as increasing skills in emotion regulation and practical skills to survive crises.
1. Gough, K	Guidelines for managing self-harm in a forensic setting	2005	Multiple literature sources drawn for literature review (not specified).	Literature review of evidence base around working with self-harming clients. Literature review then used to inform and produce guidelines and rationale for how to work with self-harm specifically in forensic services.	Guidelines produced specifically for SAFS staff in managing self-harm, covering relational, procedural and risk assessment management approaches.
1. Grocutt, E	Self-harm cessation in secure settings	2009	Security level not specified; Women only.	Qualitative study using in depth interviews of seven women having stopped self-	Themes identified by IPA relating to self-harm cessation, including; Taking control back, role of relationships and pride and achievement. Author reflects on this research and provides

				harming, using Interpretive Phenomenological Analysis (IPA).	narration on the importance of the provision of secure relationships with staff, with units approaching client care within an Attachment based model to address complex needs of client group. Ongoing training and supervision of staff is emphasised.
1. Wheatley, M 2. Austin-Payne, H	Nursing staff knowledge and attitudes towards deliberate self-harm in adults and adolescents in an inpatient setting	2009	Medium secure adult and adolescent ward staff member (n=76);	Cohort study; Staff survey using questions relating to clinical vignette based on Attributional Style Questionnaire, Emotional Response rating scale, and knowledge and attitudes questionnaires	Findings supported attributional theories which suggest staff views on self-harm are linked to the individual's ability to help the client- and that emotional responses additionally play a role in their response to self-harming clients. Study found that when staff reported feeling negatively towards self-harming clients, they experienced more worry working with this client group. Non-significant trends were noted that when staff felt more effective in their work, less negativity and worry was reported about working with the client. Gaps in knowledge about self-harm were observed in some staff, and an emphasis was placed on the importance of training and supervision of all staff, particularly unqualified staff members.
1. Gallagher, J 2. Sheldon, K	Assessing the functions of self-harm behaviours for dangerous and severely personality disordered males in a high secure hospital	2010	High secure ward. Men only (n=53).	Retrospective study of self-harm incident data using thematic analysis to explore functions of self-harm, context of incident and staff response.	Most common function of self-harm was emotional regulation, expression of anger and desire to influence emotions/ behaviours of others. Highest rates of self-harm were identified in private areas such as bedrooms or seclusion rooms. Most common staff responses to client self-harming were provision of first aid, "advice", and increased staff presence. Implications for practice include individualised management plans and further staff training.
1. Sarkar, J	Short-term management of repeated self-harm in secure institutions	2011	Security level not specified/ general secure forensic services.	Individual commentary on risk management interventions for staff on secure wards to assess and respond to self-harm incidents.	The author advocates the implementation of a 'risk algorithm' for staff to manage clients who self-harm based on three domains; 'lethality' of the act, 'intentionality' of the patient and 'inimicality' factors (setting where self-harm took place). Staff response to incident of self-harm is then dictated by assessing these risk factors in the algorithm.
1. Sarkar 2. Beesley	Developing an algorithm of hierarchical model of	2011	Enhanced Medium Secure forensic:	Implementation and audit of model of risk management	Testing of the algorithm designed in (Sarkar, 2011) paper. Manual was designed to guide algorithm implementation for

	management of repetitive self-harm among women with severe personality disorders in medium security		Women only.	efficacy on women's medium, secure forensic inpatient ward.	staff. Decrease in self-harm rates were observed over 41 month period, and high level of fidelity to model was noted in staff interventions of managing self-harm incident.
1. Birch, S 2. Cole, S 3. Hunt, K 4. Edwards, B 5. Reaney, E	Self-harm and the positive risk taking approach. Can being able to think about the possibility of harm reduce the frequency of actual harm?	2011	Medium Secure forensic ward. Women only (n=45).	Service audit of client self-harm incident data.	Advocating possibility of positive risk taking approach on secure unit, with an emphasis on relational security. Audit found rates of self-harm decreased over time with within a service provision which models thinking about risk sensitively, and considers the underlying psychopathology of self-harm.
1. Adamson, V 2. Braham, L	Pathways to episodes of deliberate self-harm experienced by mentally ill men in a high-secure hospital over the course of their lives: an exploratory study	2011	High secure forensic service. Men only (n=7).	Cohort Qualitative study using audio-taped semi structured interviews of male service users analysed using grounded theory methods.	Two 'pathways' to self-harm were identified in this client group; 'response to mental health problems' and 'relief'. These different pathways were felt to require different staff and treatment approaches. Directly addressing positive symptoms of Schizophrenia is valuable to the mental health problems pathway, whereas enhancing problem solving skills and cognitive style were advocated for when working with the relief pathway.
1. Sandy, P 2. Shaw, D	Attitudes of mental health nurses to self-harm in secure forensic settings: a multi-method phenomenological investigation.	2012	Staff from multiple secure forensic settings across London (n=61).	Use of Interpretative Phenomenological Analysis (IPA) of nursing staff interviews (n=25) and six focus groups from secure forensic nursing staff across London, UK.	IPA indicated high presence of negative staff attitude, particularly towards clients who frequently self harm. Individualised care and respect were advocated, however "condescending" approaches to clients were reported by some participants. Active listening, respect and empowerment of clients was considered important in managing self-harm and increased client involvement in care planning. Feelings of anger and frustration directed towards the client were identified. Emphasis placed on need for specialised staff training.
1. Sarkar, J 2. Beeley, S	Experiences of staff managing self-harm algorithmically	2013	Enhanced medium secure: Women only	Qualitative exploration of staff experience and understanding of how to manage risk of self-harm using hierarchical risk management algorithm using semi-structured interviews and thematic analysis.	Themes identified focused on; providing medical treatment on the ward; the need for individualised risk assessment; the model's usefulness in decreasing staff time spent managing self-harm, graded approach to managing self-harm based on model's risk assessment levels, and how to support temporary staff on the ward in managing self-harm in line with the proposed model.

Table 1: Literature included from systematic review.

Review of Studies

The papers included in this review will be evaluated directly in relation to the research questions. After each research question is addressed by the existing literature, a critique will be provided, focusing on a range of issues including methodology and study design. A summary is then provided for each question.

Question One: What approaches for directly working with clients who self-harm in UK forensic wards are presented in the literature?

To answer the above question, dominant themes addressing different elements of the management of self-harm from the included literature were identified. These themes are individually considered below.

Self-harm specific risk assessment

In a series of related studies (Sarkar, 2011; Sarkar & Beeley, 2011; Beeley & Sarkar, 2013) Sarkar (2011) designs a short-term strategy for managing self-harm formed from specific risk assessment practices.

The author emphasises the need to assess risk of self-harm across a number of domains, including ‘lethality of the act’, ‘intentionality of the patient’, ‘inimicality factors’ and ‘staff response and allocation’. Lethality of the act is divided into ‘highly lethal’ (such as hanging or strangulation), ‘less lethal’ (tissue damage such as biting, scratching, insertion into skin,) and ‘non-lethal’ (i.e. where no tissue damage is present). Lethality must then be combined with ‘intentionality of the act’, which

should reflect the “*individual’s intensity of desire or wish to die*”, as objectively assessed by the staff member and the environmental context of the act. ‘Inimicality’ or environmental factors are elements of the risk domain which speak to location in which a person chooses to self –harm (e.g. secretive versus public space in which self-harm is carried out). See Table 2.

Risk Assessment Domain			
	Lethality	Intention	Inimicality
Low Risk	Biting, scratching, gouging, head banging, sticking pins into skin etc.	Assessed through subjective consideration of interplay between lethality and	Act carried out in pen ward areas, communal areas etc. Intention to self harm expressed to staff.
High Risk	Hanging, strangulation, poisoning, electrocution, drowning	inimicality.	Act carried out in confined, secluded areas, between staff checks/ observations. Little or no expressed intention to self harm.

Table 2: Risk assessment domain examples of low and high risk of self harm act, summarised from Sarkar (2011).

The author draws upon established evidence to ground his model, however no stipulation as to the method of data inclusion was provided. Although a somewhat personal commentary, the paper positions itself in the body of clinically relevant work which considers how to managing challenges within a clinical setting (Barker, Pistrang & Elliott, 2003), as well as recognising that such work emerges from the busy world of clinical practice (the “action setting” as described by Weiss, 1972).

Sarkar and Beeley (2011) go on to use the risk algorithm outlined in the previous paper, to structure a five-level hierarchical model to manage repeated self-harm which maps the levels of severity/ risk of the self-harm act to the level of staff response required to manage it. Sarkar and Beeley (2011) audited the effectiveness of

the algorithm by examining self-harm incident data over a 41 month period, arguing that a reduction in self-harm occurred, falling from one incident per week, on average, to 0.25 per week. The author's argue that by producing a theoretically grounded, clinically informed and stepped care approach to the management of self-harm in the short term, this objective risk algorithm offers a valuable management tool which supports research stating that it is more beneficial to assess risk of self-harm based on methods used, than relying on patient explanation of the act (Maddock et al, 2010).

The final paper in the above series explores the experiences of the SAFS staff team who have been trained to implement the self-harm risk management algorithm (Beeley & Sarkar, 2013). Using semi-structured interviews, staff views of implementing the risk hierarchy were explored. Seven relevant themes were identified using a thematic analysis (see table 3).

Theme Identified from Thematic Analysis	Illustrating Quotation
1 Use of seclusion	<i>"If [physical observations] are necessary then six people [i.e. a response team] would enter seclusion to manage the risk to staff".</i>
2 Use of medical staff and outside agencies	<i>"We manage as much as we can on the unit. The duty doctor will decide whether the behaviour is life threatening, in which case we may need to [ring] 999... [for] an overdose we would call the pharmacy".</i>
3 Confidence in using the approach and its effectiveness	<i>"It is always going to be challenging with such serious self harm. Over two years the majority of staff have become confident".</i>
4 Care planning	<i>"Knowing the patient and the early warning signs is very important"</i>
	<i>"...Important [also] are individualised care plans</i>

		<i>looking at different types of self harm”.</i>
5	Safety of staff and patients	
6	Development of the approach	<i>“Practice was developed in response to the patient”.</i>
7	Experience of staff who normally work on other wards working with this approach	<i>“If people are not working here regularly then it can be difficult for them to understand. Sometimes they are concerned about safety or are not used to seeing the behaviour regularly”.</i>

Table 3: Themes and relevant quotations identified from Thematic Analysis of staff experience using Sarkar & Beeley (2011) algorithm for managing risk (Beeley & Sarkar, 2013).

Beeley and Sarker (2013) usefully draw on the evidence from staff feedback to produce direct implications for practice on secure forensic ward (see figure 3).

Implications for Practice

- Nursing staff describe the algorithmic approach to managing self-harm in use on this ward as safe and effective and it could usefully be trialled in other areas which manage difficult and potentially high-lethality self-harm.
 - The model addresses important aspects of clinical practice with self-harm and is suitable for reducing risk and harm with a wide variety of types of self harm and across the range of motivations and functions for these behaviours, reducing risk in a non-punitive fashion, recognising the role of self-harm as an affect regulation and anti-suicide strategy, and reducing the potential for reinforcement of self-harming behaviour.
 - Balancing the safety of staff and patients when managing high-lethality self-harm with the possible risk of violence can benefit from a model-based approach.
 - Individualised risk assessment and care plans can work alongside an algorithmic approach to ensure that risk is managed without over or under-response.
 - Understanding the unique history of patients on the ward with regard to self-harm and suicidality (and violence, for some patients) is essential for safe management of these patients.
 - Although this approach was considered useful and effective by ward staff, they described the model as “go[ing] against the grain” for individuals who worked temporarily on the ward and this is a useful focus for further evaluation and development
-

Figure 3. Implications for practice from implementation of hierarchical algorithm for risk management (Sarkar & Beeley, 2011) from staff feedback in Beeley & Sarkar (2013).

Research aims were clearly outlined in all of the above papers above papers and ethical approval was sought. In the 2013 paper, demand characteristics and socially desirable answering on the part of the staff team requires significant consideration, as one might assume that the seniority of the author (Consultant Psychiatrist) within the ward might shape staff evaluation of the model in interview. The design, implementation and evaluation of the model was also carried out only with female patients from a single secure unit, hence wider applicability of the model remains somewhat unclear. In line with CASP critique, the above paper appropriately utilises a qualitative data analysis approach, given the need to elucidate staff experiences of implementing the risk algorithm, and research aims were clearly outlined. However, the neglect of the 2013 paper in considering the relationship between research and participants, and the absence of coherent descriptions of which staff were or were not recruited, remains a significant critique within CASP guidelines for high quality qualitative research.

Generic guidelines specifically for secure and forensic staff

In a more holistic approach to understanding the management of individuals who self-harm, Gough (2005) drew evidence from the limited literature to produce guidelines specifically for SAFS staff. From this literature, Gough (2005) formed twelve superordinate domains to guide clinicians' work specifically within the context of SAFS. See figure 4 for recommendation outlines.

Guideline Recommendations

1. Record the details of all incidences of self-harming behaviour in order to detect any patterns
 2. Ensure that all injuries caused by self-harming behaviour are physically examined and treated
 3. Ensure that all staff use a consistent approach to managing the self-harming behaviour
 4. Ensure that attention and support are given at times when the person is not engaging in self harming behaviour
 5. Be non-judgemental in responding to a person who has self-harmed
 6. Encourage the person to engage in psychological treatment to gain further understanding of their self-harming behaviour
 7. In working with a person who has a background of self-harming behaviour, try and instil a sense of hope for the future
 8. Try to encourage people who self-harm to develop and use problem-solving skills
 9. Avoid applying additional pressure on the person not to self-harm
 10. Have a strategy or care plan for responding to a person who reports that they want to self-harm- somewhere safe they can go when they feel overwhelmed, an opportunity to talk about their feelings
 11. Try to foster a sense of empowerment in individuals who self harm
 12. Ensure that staff working with people who self-harm are adequately supported
-

Figure 4. Recommendations outlined by Gough (2005) for management of self-harming behaviour.

As an example, Gough (2005) cites the work of Babiker & Arnold (1997) who indicate the potential for self-harm to become an “attention-seeking” behaviour, however the author makes practicable suggestions on how to manage this dynamic (i.e. to provide support and attention to clients at times when they are not harming themselves; recommendation four). The guidelines provide useful strategies, covering several domains, with particular emphasis on the positive aspects of care, such as fostering empowerment, hope and non-judgemental responses.

The above paper is essentially a construction of strategies based on one clinician’s interpretation of a sparse evidence base. However, the paper stands alone in its aim to address the absence of management guidelines of self-harm for SAFS staff, and appears consistently throughout literature for managing self-harm fifteen years after its publication, irrespective of its potential bias or lack of scientific rigor.

Psychological interventions and approaches to manage self-harm

Birch, Cole, Hunt, Reany, and Edwards (2011) present data commenting on the frequency of self-harm across a secure forensic women's service using incident data reports. Birch et al. (2011) found that rates of self harm significantly reduced over time within the service, and overall, rates of self harm were significantly lower 3 months prior to discharge ($M=1.63$, $SD=2.86$) than the first three months of admission ($M=4.97$, $SD=6.49$); $t=3.467$, $df=40$, $p<0.0001$). The authors' argue that through establishing a secure attachment with their clients (a dynamic of relational security), the overwhelming and painful emotions of the client who self-harms are heard and accepted by staff- but presented back to the client in a more manageable, tolerable form. Birch et al. (2011) posit that practices such as physical restriction or attempts to control self-harming behaviour by staff, are potentially emotionally damaging and disruptive to the building of positive relationships between staff and clients.

The above paper includes quantitative illustrations to demonstrate rates of self-harm in the service, and usefully is able to map these across a four year period, arguably indicating some role of the relationship which will develop between staff and clients over this time period. The authors acknowledge the limitations of the study, including its limited sample size ($n=45$), and thus further statistical analysis is not provided to explore correlation. Ecological validity appears high, and given the audit nature of the study it appears ethical approval was not required. The absence of a control group, or comparison of incident data from other wards is not provided, so the definitive role of the relational approach outlined on decreasing rates of self-harm

cannot be conclusively separated from other factors (e.g. effects of regular medication).

Low, Jones & Duggan (2001) write about the implementation of Dialectical Behaviour Therapy (DBT; Linehan, 1993b) for women in a high secure hospital to specifically address self-harm. Ten women participated, all of whom had a diagnosis of Borderline Personality Disorder. Each woman received one hour of DBT skills training a week for one year. Incident data relating to self-harm for the women was examined prior to, throughout, and after the DBT intervention. Psychological measures were also collected pre-intervention, at 4, 8 and twelve month intervals during the therapy and at a 6-month follow up session (see Appendix c for measures used).

Eight of the ten clients showed a significant reduction between pre- and post-treatment rates of self-harm, one saw an increase, and one showed no change. However by six months all 10 patients showed a reduction in rates of self-harm between pre-treatment and the final 6-month follow up period. At four months a significant decrease in dissociative experiences, impulsiveness and symptoms of depression were found, including a significant increase in 'surviving and coping beliefs'. The end of treatment saw a maintenance of this significant difference in dissociative experiences and higher coping skills.

Given the nature of the study, a direct correlation cannot be ascertained between the intervention and reduction in self-harm as no control group was included. However, improvements on the psychological measures go some way to explain mechanisms of change within the treatment period and might provide some support

for the efficacy of DBT for reducing self-harm. The study provides no information on the ‘therapist’ delivering the DBT intervention, therefore level of qualification/ experience of the model cannot be considered- nor can the pre-existing relationship between the participant and therapist. Recruitment criteria were outlined, however no ethical considerations were explored, nor were details of client consent to participate in the study.

Low, Jones, Duggan, MacLeod and Power (2001) present three case studies of women having participated in the year long DBT treatment of their previous paper (Low, Jones & Duggan, 2001). DBT Skills felt to be particularly useful to the cases presented included behavioural strategies to increase coping skills, emotional regulation work, distress tolerance and practical skills to help during times of crisis.

The authors offer no account for the inclusion of the three cases, out of the ten women having participated, and concerns may arise that favourable cases were selected to support the intervention approach. No explanation is provided as to the viewpoint or positioning of either the author, or the member of staff providing the intervention presented in the case studies, introducing the possibility researcher bias, or preferential participant selection and reporting. The paper does however usefully reflect upon the challenges of providing a psychological intervention for managing self-harm within a high secure ward, and goes some way to addressing how to manage these challenges. The authors’ acknowledge that “*security overrides everything else*” but that with flexibility the intervention was still delivered within these constraints. The acknowledgement that security procedures will supersede therapeutic interventions is important when considering how to manage self-harm in secure services, particularly within the DBT model which emphasises skill implementation

and coping strategies which may not be factored into the regimented ward routine. As in the above paper, issues of client consent to participate are not addressed.

Grocutt (2009) provides a useful perspective on the centrality of the relationship between staff and their clients who self-harm, based on the unpublished thesis of her D.ClinPsych. Grocutt (2009) draws on her research experience using Interpretative Phenomenological Analysis (IPA) to analyse interviews from women who, despite having complex histories of self-harm, no longer reported self-harming. Drawing on the themes from this research, the author provides a narration on how secure inpatient services can foster certain psychologically informed approaches in the hope of decreasing self-harm for individuals in their care. Significant emphasis is placed on the relational aspect of managing self-harm, along with the advocating of therapeutic environments based on attachment theory (Bowlby, 1988). The above chapter offers a unique perspective in considering how best to care for clients who self-harm in secure services, couched in the experiences of service users, arguably demonstrating high ecological validity of the findings, which the author then expands into recommendations for practice and forensic service development.

The author relies heavily on attachment theory and relational aspects of care, however little expansion is provided as to how this is achieved within everyday clinical practice. Emphasis is placed on the need for staff training, however this term, as in other papers, remains somewhat 'ethereal' as no specification is provided as to what, how or to whom this training should be provided. Given the qualitative nature of the research, and the potential for subjectivity, the author does not reflect on her theoretical positioning or her relationship with the participants. Although categorised as 'grey literature', Hopewell, McDonald, Clarke & Egger (2008) argue that such

literature is better able to reflect negative or inconclusive data and hence warrants inclusion if relevant to the review topic.

Assessing individual meaning of self-harm to inform management

Adamson and Braham (2011) present an exploratory study using grounded theory to identify the life-span pathways which led men in a high secure hospital to self-harm. The paper provides a very rare insight into the experiences of men in high secure services with mental illness relating to self-harm, and usefully moves away from trends in the evidence base focussing solely on women, or with an emphasis on those with a diagnosis of borderline personality disorder (Shaw, 2002). Issues of ethical approval and consent collection were excellently outlined in the paper, and staff teams were consulted on whom to approach within the unit, both considered significant strengths in accordance with CASP for qualitative research. The methodology appears to show good fidelity to the Straus and Corbin (1994) approach to conducting grounded theory, however at no point do the authors comment on their theoretical positioning or demonstrate the use of a bracketing interview (Fischer, 2009). An independent rater was unavailable to co-rate interview coding, therefore no opportunity to explore the authors' subjectivity relating to data analysis has been provided. Implications for staff practice are provided, and present useful guidance on the different ways of managing self-harm in SAFS, depending on the experiences and difficulties of the individual client. Perhaps the most significant critique of this work is that no participants were currently self-harming or had self-harmed in the high secure setting- leaving the validity of the results under significant query, and application of the findings to other secure services may be unhelpfully limited.

Gallagher and Sheldon (2010) present a paper exploring the functions of self-harm in a high secure hospital for males with a diagnosis of dangerous and severe personality disorder (DSPD; a diagnosis obtained for individual's considered to have severe personality disorder and high risk of harm to others; Duggan, 2011). Using data from 29 participants (386 incidents), incidents were coded using thematic analysis which provided ten proposed functions of self-harm within the target population, including; affect regulation, sensation seeking, psychosis, control and interpersonal influence. Incidents of reported self-harm were then analysed to map fidelity to these codes. Staff management responses were also identified (*see figure 5*).

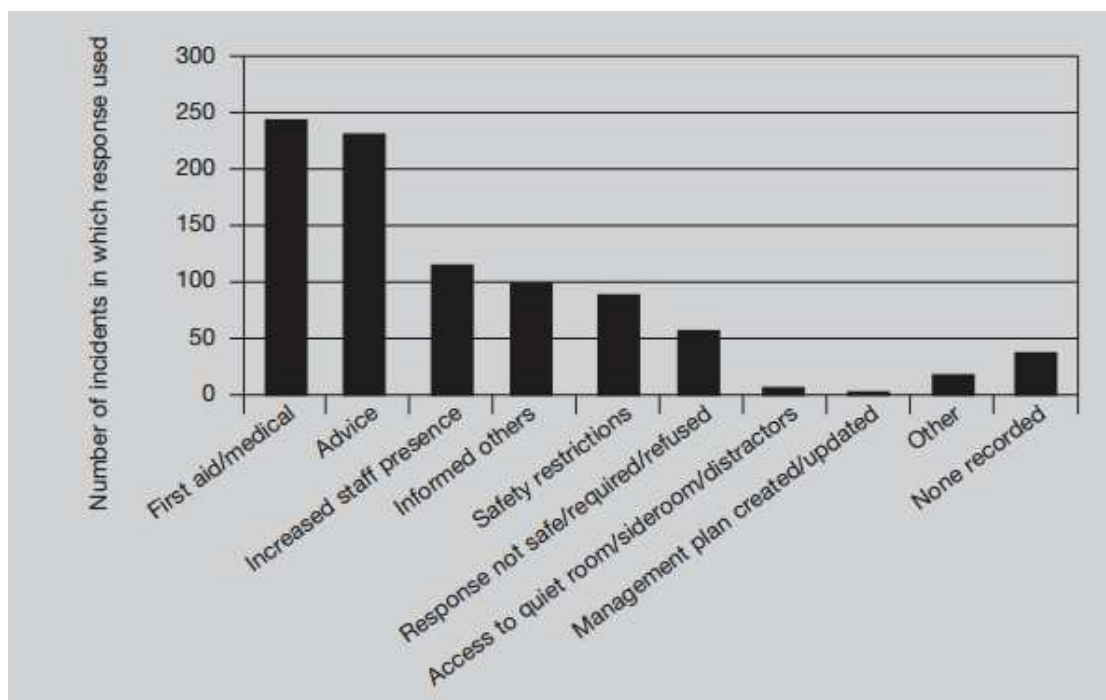


Figure 5. Staff management responses to incidents of self-harm on high secure unit (Gallagher & Sheldon, 2010).

The approach used by staff most frequently to manage self-harm was applying first aid, closely followed by 'advice'. Physical security management strategies such as increasing staff observation, safety restrictions and use of quiet rooms appear to be the most frequent approaches used in this context.

Inter-rater reliability was sought and showed good consensus, and two iterations of the thematic analysis were conducted to include additional themes which were felt to more accurately capture the functions of self-harm incidents reported. Ethical approval and considerations were not discussed, however given the use of retrospective incident data, ethical approval to an external panel is unlikely to have been required. Useful quotations were included to demonstrate themes. The most significant concern for this research is the reliance on staff completed incident forms to generate thematic codes; interpretation is thus based entirely on the subjective understanding of the staff member and hence prone to reporter bias, potentially bringing into query both the reliability and validity of the study findings. In accordance with CASP guidelines, the above paper struggles to adhere to the need for robust and coherent data analysis, particularly around the way in which codes for the thematic analysis were generated, and the reliability of the data on which these codes were founded.

Summary

This review asked in what ways the current literature advocates the management of self-harm in secure forensic units. Female populations are significantly over represented in the papers presented, with six papers reflecting a female population, two with males and two which do not specify. All papers using a female sample also all include participants with a diagnosis of borderline personality disorder, with only the Gallagher and Sheldon (2010) reflecting males with DSPD and Adamson and Braham (2011) including a male sample all with a diagnosis of schizophrenia.

Dominant themes from the literature used to answer this question appear to fall into four main categories: ‘Psychological interventions and approaches in managing self-harm’ (Low, Jones & Duggan, 2001; Low, Jones, Duggan, MacLeod & Power, 2001; Grocutt, 2009 and Birch et al., 2011), ‘self-harm specific risk assessment’ (Sarker, 2011; Sarkar & Beeley, 2011 and Beeley & Sarkar, 2013), ‘assessing individual meanings of self-harm to inform management’ (Gallagher & Sheldon, 2010 and Adamson & Braham, 2011) and ‘generic guidelines for staff managing self-harm’ (Gough, 2005).

The above studies represent the few attempts to explore explicitly the strategies used to care for clients who self-harm within UK secure forensic wards. Robust scientific research studies appear absent within the above literature- with no use of control groups or consideration of other potentially therapeutic factors (e.g. medication). Personal commentaries on service provision (such as Grocutt, 2009, & Birch et al., 2011) reflect work which may fall into the sphere of “naturalistic field work”, which holds value in its ability to identify a problem and explore a solution offering insight into how services might best face these challenges (Bebbington, Marsden & Brewin, 1997). All Studies also show small sample sizes.

Birch, Cole, Hunt, Reany and Edwards (2011) provide a psychodynamically informed commentary of self harm audit data from a secure forensic women’s service which advocated a relational security approach and elements of positive risk management, and therefore provide a longer term model of care than the risk assessment specific series of papers. This paper is matched in the approach advocated by Grocutt (2009) who also places the emphasis on developing secure and containing relationships between self-harming clients and staff. Management of self-harm on

secure forensic units is modelled with emphasis on building relationships, providing containing and empathetic staff responses to clients and non-restrictive approaches to the client's wish to harm themselves, through providing support and company at times when the client is struggling with difficult emotions, as well as encouraging responsibility and agency on the part of the client to care for their wounds- as well as the general shared environment of the ward in an attempt to facilitate empowerment for the client. Gough & Hawkins (2000) additionally provide emphasis on the need of relational care management, outlining the importance of empathy, hope and compassion in working with clients who self-harm.

Gough's (2005) paper draws on previous literature to produce specific management recommendations, however it is acknowledged from the outset of the paper that due to the limited evidence base, finding relevant data at the time of writing was challenging. The recommendations, therefore, appear to be a synthesis of data from populations which may not include or reflect upon the specific nuances of managing self harm in secure forensic services. Gough (2005) bases these recommendations on feedback from her previous research with staff members on forensic wards, and hence her work holds a helpful acknowledgement and reflection from the comments and needs of front line staff, demonstrating a potentially high level of ecological validity.

Sarkar (2011) offers an interesting risk-based approach to the short term management of clients who are harming themselves in secure forensic services, but what remains absent is a more longitudinal consideration to risk management, a factor which is likely to become increasingly complex as the client and staff develop relationships over, what can be several years in a service. Unlike other papers

included emphasising the importance of relational working, Sarkar (2011) conceptualises self-harm as an act of affect regulation, a position which may result in the more complex dynamics of the act becoming dismissed or overlooked in the application of the proposed management model.

Gough's (2005) guidelines are valuable, and as they include evidence from staff feedback. This needs assessment element of the paper, based on the assumption there is a problem which has a potential solution to be met (namely how best to manage clients who harm themselves in forensic secure wards) is useful in meeting relevant staff and service needs (Bebbington, Marsden & Brewin, 1997). Gough (2005) provides management strategies which usefully address issues of risk, staff engagement, psychological intervention, care planning and record keeping, however the paper does not address how such guidelines might be either practised or understood by staff currently working in secure forensic services. Watts (1984) argues that gaining material directly from staff and services (e.g. 'naturalistic feedback') is often a favoured method of service leads and policy makers, over traditionally more robust research design, when hoping to create changes to existing ways of working.

Low, Jones and Duggan (2001) and Low et al. (2001) explored the efficacy of a psychologically informed intervention on a high secure unit specifically for its impact on self-harm incidents, which provides useful insight into the management of self-harm within this specific services. Incidents of self-harm decreased after a DBT skills weekly session, however with a small sample size of only women, the study has obvious limitations. The authors argue for the positive role of coping skills training for managing self-harm, perhaps connecting with the notion of the empowering service philosophy advocated by Grottt (2009) and Birch et al. (2001).

Adamson and Braham (2011) and Gallagher and Sheldon (2010) promote the need to assess the individual meanings behind self-harm, arguing that this will shape the management approach applied with that person. Unlike other studies, staff management techniques used to address self-harm were provided, showing a rare insight into what practices are used by staff 'on the ground'. An all-male sample, however, does not provide a gendered understanding of the act of self-harm, and it cannot be assumed that study findings would, for example, translate to female clients in a low secure setting.

Question Two: 2. In what ways do secure and forensic staff view clients who self-harm, and what is their understanding of how to work with these individuals?

Gough and Hawkins (2000) conducted a staff survey of attitudes towards service users who self-harm within a forensic inpatient service. A questionnaire comprising of 23 statements was disseminated to staff from a forensic inpatient ward, whereby respondents rated on a 1-5 Likert scale the extent to which they agree with the statement (see figure 6).

1. People who self-harm do so to seek attention
2. There is an underlying cause(s) for self-harming behaviour
3. Discipline/firm words are helpful in managing self-harm
4. People who self-harm are often selfish people
5. Self-harm is a serious problem
6. Self-harm is often an impulsive behaviour
7. If someone is overtly responsible for their self-harming behaviour they should reap the consequences of their act
8. Showing sympathy to someone who has self-harms merely reinforces an unhelpful behaviour
9. A minimum amount of attention should be paid to someone who repeatedly self-harms
10. A self-harmer is at a greater risk of suicide

11. Every effort should be made to remove any implements that could potentially be used to self-harm from a self-harmer's immediate environment
12. Self-harm is an attempt at committing suicide
13. Self-harm is almost entirely a woman's problem
14. Self-harm is often seen as an effective coping strategy by the individual
15. Self-harm is often a method used to communicate to others how distressed they are
16. Behavioural treatment programmes (including punishments and rewards) are effective at overcoming the problem of self-harm
17. People who self-harm enjoy the sensation of pain
18. Self-harming behaviour intensifies the individual's immediate feelings of anguish
19. People who self-harm are more likely to harm others as well
20. When talking to someone who you know self-harms, the less said about self-harm the better
21. Self-harmers usually want to stop self-harming
22. Dealing with self-harm wastes valuable staff time
23. Dealing with self-harm wastes valuable resources which could be more usefully used elsewhere

Figure 6. Statements in staff survey (Gough & Hawkins, 2000)

Open ended questions were also included (though not outlined in paper).

Questionnaires were piloted then sent to all hospital staff (n=156) and 77 were completed. See table 4 for professional disciplines of participants.

Profession	Response rate (n=77)
Nurse	45
Medical doctor	7
Occupational Therapist	5
Psychologist	4
Social Worker	3
Nursing Assistant	2
Technician	2
Education Tutor	1
OT Assistant	1
Profession not disclosed	7

Table 4: Staff professional background for survey completion (Gough & Hawkins, 2000)

Cluster analysis of data revealed two groups, one of which appeared to hold more punitive or negative attitudes towards self-harm. Neither profession, qualification, age, experience or work base accounted for the difference in the two

clusters after using discriminative analysis. Respondents were then asked an open ended question as to what their understanding was for why people self-harm which the authors categorised under three headings: 'Underlying factors/ vulnerabilities to self-harm', 'Feelings/Experiences Precipitating self-harm' and 'Function served by self-harm'.

Staff listed the use of personal qualities such as sympathy, empathy, non-judgemental approach, support and counselling in their current role of helping people who self harm Medication, physical first aid, observation and assessment, and management and decision making were also listed as aspects of care for those who self-harm. Specific therapeutic modalities were listed as being what staff felt was most valuable for their patients, listing 'Cognitive Behavioural Therapy', 'Behavioural approaches', 'psychodynamic approaches' and 'educational support'. Some staff advocated the position for managing self-harm in a facilitative approach, for example "*allow the individual the opportunity to self harm and then talk it through*", versus the restrictive/ preventative approach; "*removing any potential self-harming instrument from the individual*". Gough & Hawkins (2000) additionally noted that staff who felt more qualified and trained in managing self-harm also reported greater understanding on self-harm.

The above paper is another to be situated within the clinically relevant pool of writings for how to manage self-harm within SAFS, but which does not meet the robust characteristics of a methodologically sound paper. Again, such work should not be dismissed. Watts (1984) argues that such work is popular with policy makers and service leads (more so than methodologically robust, peer reviewed work) when

attempting to create changes in ways of working within teams. Issues of consent were not addressed.

Wheatley & Austin –Payne (2009) conducted a staff survey of nurses working across adult and adolescent secure forensic wards with both males and females (see table 5 for staff demographics). Wheatley & Austin-Payne (2009) administered three questionnaires; a vignette questionnaire, the ‘knowledge and attitudes questionnaires’ and lastly a set of demographic questions.

	Adult Service Staff	Adolescent Service Staff	Total
Female Staff	10	7	17
Male Staff	26	19	45
Gender not stated	13	1	14
Qualified Nurses	28	9	37
Unqualified Staff	21	18	39
Group Total	49	27	76

Table 5: Demographic information of staff completing survey (Austin-Payne, 2009).

The vignette was formed from various measures, including the ASQ (Attributional Style Questionnaire; Peterson, 1982), the Emotional Response Rating Scale (Weiner, 1980), the Optimism/Pessimism Scale (Moores & Grant, 1976) and the Helping Behaviour Scale (unreferenced). The Knowledge and Attitudes Questionnaire was developed from Crawford (2003) to make wording applicable to service staff. Findings from the study supported the attributional role of Peterson (1982), with authors arguing that staff members’ understandings of why an individual self-harms, their emotional response to the act, their perceived efficacy in managing

the self-harm and their knowledge of self-harm in general will shape their response to clients in their care.

No ethical considerations appear in the paper, and no reflection is provided as to the potential discomfort or avoidance of staff in commenting on their clinical practice, knowledge or skills, in a battery of questionnaires sent by their employer (a factor which may be reflected in the low response rate of 12%). With this in mind, the impact of socially desirable answers must be considered. The internal validity and reliability of the battery of measures used is not addressed, nor is the impact on potential responses when wording has been amended to better fit with the target population. Self-report measures invite some criticism, with wording and order having a significant impact on results (McColl et al., 2001) and the number of potential biases present in this data collection method (Fiske & Taylor, 1991).

Sandy and Shaw (2012) identified themes emerging from individual interviews and focus groups with SAFS mental health nurses using IPA (see table 6). In total, positive attitudes were identified at 136 points across the interviews and focus groups, compared to a total of 178 times for negative.

Super-ordinate Themes	Sub-Themes	Keywords or Phrases	Individual interviews: Number of times themes mentioned	Focus group interviews: Number of times themes mentioned
Attitudes to self-harm	Positive attitudes			
	Acceptance, Readiness and engagement	Listen to them	15	12
	Optimism	Hopeful	3	10
	Partnership working	Care planning	6	10
	Provision of choice of activities	Provision of choice	11	15
	Need for training	Training	19	35
	Negative attitudes			
	I don't care	I don't care	20	20
	Rigid-authoritative approach	Controlling	19	25
	Labelling and prejudice	Time wasters	17	30
	Blanket approach	Same group of people.	13	15
	insensitive expressions	Do it when I am not here	9	10

Table 6: Attitudes emerging from staff interviews and focus group on views of self-harming clients (Sandy & Shaw, 2012).

The authors clearly outline issues of ethical considerations, staff consent, recruitment selection procedure, as well as specifically stating the measure of quality applied to the data analysis (the authors used a framework of trustworthiness based on Guba & Lincoln, 1994 to ensure scientific rigour). Validity appears high, as multiple professionals provided and checked transcript analysis, and staff provided feedback on transcript accuracy. However, the impact of discussing professional practice amongst colleagues may have lead to socially desirable answers, and focus groups can be swayed by narratives of more dominant participants. No exploration of the authors' positioning of self-harm management, nor use of a bracketing interview was detailed, which is significant given the IPA technique adopted (Rols and Relf, 2006).

Summary

This question aimed to explore views of SAFS staff on self-harm and their work with this client group. Included are three staff cohort studies, two utilising

quantitative cohort surveys, one using IPA analysis of staff interviews and focus groups.

Two of the three above papers only access the views and experiences of nursing staff (either qualified or unqualified) and nurses comprised the highest proportion of staff surveyed by Gough and Hawkins (2005). Gudjonsson and Young (2007) comment on the high percentage of time that clinical psychologists spend engaged in patient-related work (67%) or in supervision with other ward staff (11%) on a high secure SAFS unit, and hence capturing the views of this staff group, to name but one, is something which appears to receive less focus in the literature.

Negative attitudes towards clients who self-harm were identified by all three papers, commonly including themes of manipulation and attention seeking as motivators of self-harm in this client group. A lack of training and specialised knowledge about self-harm and its meanings were commonly expressed by staff; with Gough and Hawkins (2000) and Wheatley and Austin-Payne (2009) suggesting that when staff feel less concerned about their knowledge and skills regarding self-harm, they feel more able to manage their clients. In a more methodologically robust study, Sandy and Shaw (2012) additionally highlighted negative staff views towards clients who self-harm, and identified themes of applying ‘authoritative-rigid’ or ‘blanket approaches’ of care, as staff struggled to provide individualised care approaches in the high-stress environment of secure forensic wards. All the above papers were able to identify arguably more optimistic themes in their studies, commenting on important elements of management practice such as empathy, partnership working and hopefulness, suggesting staff were able to understand the impact of their views and beliefs upon clients with whom they work.

The above studies go some way to explaining how the management of self-harm in SAFS can be mediated by the internal state of the member of staff providing care. Whether this be the knowledge held about self-harm, the emotion evoked by the individual harming themselves, or the perceived skills and efficacy of that person to manage the incident of self-harm- management provided by the staff member will be affected.

Discussion

Exploring the management of self-harm in SAFS is an important area of focus, given the complexity of care required in this population and the unique challenges of balancing risk management and effective psychological support. Within the context of management approaches, staff views, understanding and attitude towards self-harm are pivotal given staff are responsible for implementing such management strategies.

Broad domains of management are advocated for within the literature including risk management, relational ethos of service/unit and the use of specific interventions for decreasing self-harm. Each of the above papers offers either explicit or implicit guidelines for managing clients who self-harm.

Question one explores the management strategies outlined in the literature used in SAFS to work with clients who self-harm. Individualised approaches of care for clients appears embedded across the literature, whether by using a risk algorithm to individually assess a client, or advocating work which explores the individual

pathways for which a client has been led to self-harm. Indeed, Suyemoto (1998) discusses the significant differences between the functions of each individual's self-harm, and the need to discern between what is being communicated by the person- which is not necessarily a desire to end their life.

The importance of managing self-harm within a relational context is explicitly commented on by Gough (2000), Birch et al. (2011) and Grocutt (2009) all of whom, to varying degrees, acknowledge the centrality of the relationship between staff and client as the underpinning of all work that can be done to manage self-harm. Adshead (1998) also speaks of the attachment relationship being the core mechanism in understanding self-harm, and hence provides continued emphasis on the role of the relationship between the individual who self-harms and the staff who care for and manage them. The conceptualization in the literature of self-harm as an act of communication (Motz, 2009) also provides support to the relationship aspects of the act of self-harm, as arguably, if a person is communicating, they are expressing themselves to 'another', and therein lies the relationship.

Gallagher and Sheldon (2010) also uniquely specifically highlight how staff directly manage incidents of self-harm, showing physical security measures such as increasing staff observations and use of quiet rooms to be the approaches most often used by staff. The authors additionally identified that affect regulation was felt to be the most frequent function of self-harm in their sample, perhaps providing some support to the Klonsky (2007) review also cited affect regulation as the most commonly identified function underpinning self-harm. Of those papers explicitly

commenting on staff responses to self-harm, physical responses (e.g. increase staff observation) appear most frequently implemented. Daffern and Howells (2009) describe the role of reciprocal violence in the act of self-harm, and physical restraint has been described within the literature as a “re-traumatising” experience for some mental health patients (see Bonner, Lowe, Rawcliffe and Wellman, 2002). Therefore, the cycle of violence in the act of self-harm, through the use of physical restraint, is perhaps strengthened through such management procedures, rather than decreased.

Management strategies cannot be implemented without staff, and hence this review additionally considered how SAFS staff view self-harm. Attitudes of nursing staff appear to dominate somewhat, and although the rationale for this is sound (given the proportionally higher number of nursing staff in wards), the views of other professions (particularly those providing supervision or training to nursing staff) will likely shape the ethos of the ward and the care provided by nursing staff, and hence should not be overlooked. The frequency of negative staff views of clients who self-harm perhaps speaks to the “attack on the minds of others” as described by Campbell & Hale (1991) whereby maintaining a ‘thoughtful’ or reflective stance when faced with another’s attempt to hurt themselves becomes increasingly challenging. Perhaps then, this attack leads some staff to emotionally retreat, as a defence against their strong emotions (and those of the client), leaving instead a more critical, blunted response to the distress behind the act.

Studies included outlining management of self-harm are all conducted within a single level of security (high, medium or low). It cannot, however, be assumed that practices considered useful in a low secure setting with women, for example, will be

equally helpful with a high secure population with males. It is acknowledged that gendered approaches to managing self-harm as are essential (Women Mental Health: 'Into the Mainstream' DoH, 2002) and as such sensitivity needs to be maintained for likely gender differences in the management of self-harm in secure services.

Clinical Implications

Research evidence appears consistent that rates and severity of self-harm are highest within secure forensic settings (Walsh, 2009), however studies exploring how to manage and care for clients who self-harm in these services remain very limited. Generic strategic policies addressing the management of self-harm (NICE, 2004, 2011) remain somewhat difficult to extrapolate to secure forensic settings, and appear under-informed as to the reality of managing self-harm in such environments.

What limited evidence that does exist for how self-harm is managed in SAFS predominantly only reflects practice of single wards or services, reflecting the view that there is little consensus from staff and services across the numerous secure forensic units in the UK as to what management strategies are implemented in patient care, and how staff conceptualise or understand the care needs of clients who self-harm (Coid, Kahtan, Gault, Cook & Jarman, 2001). Variations in the approach of care provided across different secure forensic wards is understandable, however acknowledgment and further understanding of what this care involves is essential. Research conducted across units and levels of security in UK SAFS is not, to date, available, and it thus remains difficult to conceptualise what, in practice, is being done to care for clients who self-harm.

Gough & Hawkins (2000) and Wheatley & Austin-Payne (2009) both emphasised the benefit to practice of tailored staff training to further support their understanding of self-harm. This is particularly salient to forensic secure wards, as often unqualified staff (e.g. support work staff) make a significant proportion of ‘on the ground’ ward staff, and are likely to have significant exposure to the act, and staff management of clients who self-harm.

The literature frequently references the negative views of staff towards clients who self-harm, and this remains a concerning trend across the available evidence. The impact on patient care of these negative attitudes, although arguable somewhat taboo, requires a more full exploration within services given the noted prevalence of these views. Unaddressed issues of staff stress and burnout are likely to result in staff struggling to ‘think’, in an environment which is already exceedingly mentally challenging, thus management practices may tend more towards the manualised, mechanistic procedures, leaving clients’ emotional needs somewhat neglected.

Future Research

Significant research emphasis is needed to explore what current practices are being used across low, medium and high secure services across the UK to manage clients who self-harm. This would create a wider and more consistent picture than current research which predominantly narrate on the practices of a single ward or service, gender or diagnostic clustering. The efficacy of these practices, both for clients and staff teams needs additional exploration. Managing and understanding self-harm in secure settings needs to be emphasised as separate to, for example,

managing self-harm in acute or learning disability services, so again as to avoid practice recommendations which are drawn from an evidence base not comparable to the nuances of forensic secure inpatient care.

To varying extents, the literature presented here acknowledges the prevalence of negative attitudes being held by staff towards clients who self-harm. Further research is needed to explore the mechanisms which underpin these negative views, as it is recognised that such views can lead to “cynical and cold” approaches to patient care (Maslach & Jackson, 1982). Literature relating to burnout in mental health staff is quite extensive (see Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012), however identifying the processes specific to the intense challenges of forensic inpatient work may provide helpful in producing an informed, sensitive and relevant support package for staff within these care services.

Conclusion

A systemic review of the literature exploring the management practices of self-harm in secure forensic units, including perspectives on staff knowledge and attitude towards self-harm in this client group was conducted. Strategies for managing self-harm included emphasis on individualised risk assessment plans with tailored staff interventions based on severity of injury. Provision of DBT directly to address self-harm appears to be useful in reducing self-harming incidents through the teaching of coping skills and emotion regulation. Emphasis on the relational aspects of managing self-harm are present throughout the literature, advocating the central role of the relationships between staff/service and client in containing the distress accompanying

many acts of self-harm. Research examining staff attitudes, knowledge and their responses to self-harm appear to provide support for Attribution Theory, as evidence suggests that staff management and approach of self-harming clients is shaped by their beliefs, emotional response and knowledge of the act. A diverse range of understanding of self-harm from staff is also acknowledged. Significant emphasis across the literature is placed on the need for robust, informed and effective staff training on how to work with clients who self-harm.

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Appendices

Psychological Measures used by Low, Jones & Duggan (2001) to evaluate DBT intervention.

Measure	Author(s)
Irritability, Depression and Anxiety Scale (IDAS)	Snaith & Zigmond, 1994

Dissociative Experiences Scale (DES)	Bernstein & Putnam, 1986
Reasons for Living Inventory (RFL)	Linehan, Goodstein, Nielson, & Chiles, 1983
Beck Hopelessness Scale (BHS)	Beck, Weissman, Lester, & Trexler, 1974
Beck Scale for Suicide Ideation (SSI)	Beck, Kovacs, & Weissman, 1979
Beck Depression Inventory (BDI)	Beck & Steers, 1987
Impulsiveness Scale	Eysenck & Eysenck, 1991

SAMANTHA COLE BSc Hons, MSc

**MANAGEMENT OF CLIENTS WHO SELF-HARM IN UK SECURE FORENSIC UNITS: A
DELPHI METHOD**

Section B

The management of self-harm in UK secure forensic wards: A Delphi Method.

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School of Psychology, Politics and Sociology
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Abstract

Little evidence exists in the literature for how to manage clients who self-harm within low, medium and high secure forensic wards, despite the identified high rates of self-harm within these services.

This study sought to investigate the management practices used with clients who self-harm in low, medium and high secure forensic wards, how helpful staff consider these practices and what understanding staff have of the reasons for which clients self-harm.

A Delphi survey methodology was employed across three rounds using a multidisciplinary cohort of forensic ward staff, across low, medium and high secure wards.

Physical management strategies were reported as most frequently employed to manage self-harm. Relational approaches to managing self-harm showed the highest rate of consensus for their helpfulness in practice.

Consensus was reached across numerous domains explaining reasons for self-harm, including as a 'communication of distressing feelings'. Statements indicating a negative view of self-harm such as 'to manipulate staff and gain attention' received consensus of disagreement.

Psychological models and approaches used by clinical and forensic psychologists in the cohort were identified, and helpful elements of these models were identified, including 'positive focus of approach' and 'emphasis on relational working'.

Keywords: self-harm, secure, forensic, management, staff-attitudes

Introduction

Self-harm is viewed as a major public health concern (Fleischmann et al. 2008) and secure forensic inpatient units are reported as having the highest rates of self-harm across all psychiatric services in the UK (Walsh, 2009; Brooker, Flynn & Fox, 2010). Favazza (1998) described these wards as a “hot beds” for deliberate self-harm, and environments whereby the care and management of self-harming clients is most challenging (Walsh, 2009).

The National Institute for Clinical and Health Care Excellence (NICE) have produced two guideline documents for the management of self-harm (2004 and 2012) in the NHS. However the usefulness and relevance of these to the specific environments of secure and forensic inpatient wards is heavily critiqued (Sarkar, 2011). Secure and Forensic wards (low, medium and high secure) are required to meet levels of security which shape and impact the everyday functioning of the ward and significantly restrict the activities, leave entitlement and access to certain items of all individuals in their care. The management of self-harm in these environments, therefore, faces unique challenges not encountered by other wards, given the inherent physical and procedural risk policies which must be adhered to. Sarkar (2013) also argues that management of self-harm in secure forensic wards is unique due to the increased severity of self-harm in the population, the increased likelihood of aggression towards staff who intervene and the common occurrence self-harm acts being carried out in secret.

Commenting on implementing a psychological intervention for self-harm on a high secure unit, Low, Jones, Duggan, MacLeod and Power (2001) succinctly summarise the unique challenges faced when working with self-harm on secure forensic wards; “*security overrides everything else*”.

Very little literature exists examining how self-harm is managed specifically within the context of high, medium or low secure forensic units for adults. Research with this client group tend to focus on frequency rates of self-harm, or with adolescent populations (Nock & Prinstein, 2004), or focuses on areas deemed to be of higher public interest, such as such as decreasing rates of recidivism (Fitzpatrick et al, 2010). Given the very limited evidence base for how UK secure units manage self-harm, NICE guidelines on managing self-harm are considered difficult to apply. What exists then, is a gap in the evidence base exploring how self-harm is managed in the everyday practice of secure units across the UK, and if any clinical consensus exists as to the efficacy of such practices. The literature which does exist reflects the practices of single wards, specific ‘diagnostic clusters’ within these wards, or focuses predominantly on female service users (Klonsky, 2007a).

Haw, Hawton, Houston, and Townsend (2001) estimate that up to 90 percent of individuals who self-harm will meet criteria for a psychiatric diagnosis, and it is estimated that 60-70 percent of individuals within prison and secure forensic services will meet criteria for a personality disorder diagnosis. Birch, Cole, Hunt, Reany and Edwards (2011) comment on the extremely high rates of early years abuse, trauma and neglect of individuals entering secure forensic services, highlighting the significant challenge faced by secure forensic services of working with this vulnerable population.

Little interplay is explored in the research between how self-harm is managed in relation to established theories explaining the act, how self-harm is managed and conceptualised by SAFS services and staff and whether the restrictions placed upon SAFS staff can allow for a meaningful understanding of why a person harms themselves. However, what does exist is research demonstrating how staff views and attitudes to self-harm can significantly impact the way in which clients are cared for (see Gough, 2005; Dickinson, Wright & Harrison, 2009; Dickinson & Hurley, 2011) with clients who repeatedly self-harm facing the most negative staff reactions (Tantum & Huband, 2009). Wheatley and Austin-Payne (2009) exploring the role of the Attribution Model (Fiske & Taylor, 1991) found that the way in which staff evaluate the reasons and motivations for a person's self-harm, along with their emotional reaction to the act and their perceived efficacy in managing the incident-shape the response and management approach provided by that person.

Self-harm is often conceptualised as an act underpinned by its relational context; the individual's relationship with their body and self, self and other, or both. Theories attempting to explain the act of self-harm are varied, yet all appear to capture the relational context in which the act is centred within. Scanlon and Adlam (2009) explain self-harm as a means to communicate with the other, to express the pain of trauma and hurt once experienced which is not able to be spoken with words. Campbell and Hale (1991) describe a person's act of self-harm as "an attack on the minds of others", calling them into a manic reaction to prevent death, serving the person to re-experience potentially abusive and restrictive care practices which likely recapitulate early traumatic experiences.

Unusually positioning self-harm in a more optimistic light, Motz (2009)

describes how self-harm is an attack on the relational boundary, as represented by the body. In attacking ones own body, the person becomes master of their own pain and destruction (rather than at the hands of another) and through surviving the injury, can withstand the attack and experience the process of survival, rather than the likely internal or psychic destruction experienced in previous traumatic experiences.

Paradoxically, the act of self-harm thus becomes a preserver of life through the very experience of survival. Hale (1991) writes about how for those having experienced trauma and neglect, the act of self-harm allows an alternative conduit for the pain, meaning that distressing memories can be forgotten- as this internal conflict has been solved, albeit temporarily, by the destruction (and distraction) of the body.

Some theories emphasise the role of aggression in explaining self-harm, arguing that this is particularly pertinent to the clients in SAFS who, due to their offending experiences have often been perpetrators of violence towards others. Daffern and Howells (2009) explain high rates of self-harm in SAFS as due to the newly internalised feelings of aggression which, due to incarceration and restriction of secure wards, prevents the expression of this aggression towards other people (which may have been practised within the community). Mannion (2008) found that conflict on wards was the most significant antecedent for self-harm incidents, supporting the notion that clients within secure services attack their own bodies out of anger, as more procedures are in place to manage violence towards others than violence towards the self.

Adshead (1998) describes acts of self-harm as underpinned by the attachment experiences of the individual committing the act, but this is not experienced in

isolation of others; rather in the dynamic interplay between self and other, client and carer. The role of the relationship fostered between staff members and the clients for whom they care arguably becomes the most significant factor in working with self-harm, and hence the attitudes and beliefs held by staff will significantly mediate the relationships that are able to form. Sandy and Shaw (2012) noted the prevalence of negative staff attitudes within forensic ward nurses, with staff reporting that rigid, authoritative, or ‘blanket approaches’ of management were applied to clients who self-harm.

Ward security restrictions, procedural, relation and physical

Low, medium and high secure forensic wards are required to meet levels of security categorised across three domains; relational, procedural and physical security, as outlined by the Royal College of Psychiatrists (2012). These security requirements underpin all elements of care provision on secure wards, covering issues ranging from height of perimeter fence (physical security), client access to psychologists (relational) and policies required to manage a client absconding (procedural security). See Appendix A for further examples of security requirements for medium secure forensic wards.

Taken in isolation, each of the challenges facing the management of self-harm are significant, however secure and forensic wards face the somewhat unique challenge of balancing these complexities ‘under one roof’. SAFS wards need to provide care to the client who self-harms in an environment which, due to the rigorous security requirements, continuous nursing presence and high rates of trauma (or psychiatric disorder) is fraught with clinical complexity (see figure 6).

Given what is known from the literature (including the role of staff attitudes, the centrality of the relationship between client and staff, the difficulty in applying NICE guidelines to SAFS and the unique restrictions and complexities in secure wards) what is needed is clarification of what practices are used to manage self-harm. This will need to include how SAFS staff view self-harm and its meanings and how effective these management strategies are considered by those providing care.

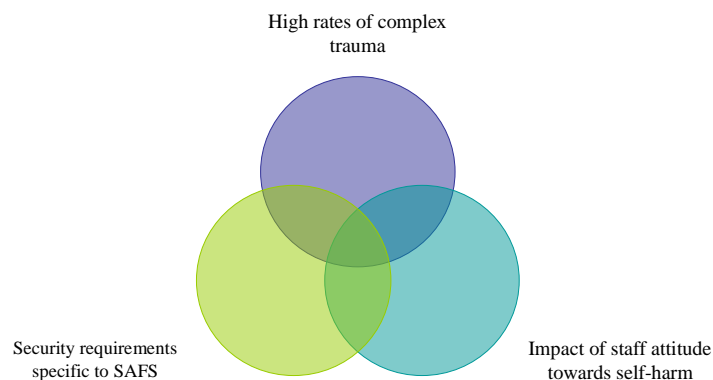


Figure 6. Complex domains affecting the management of self-harming clients specifically within secure and forensic wards.

Given the evidence available, and missing from the evidence base, this study aimed to address the following questions:

- 1) Can consensus be reached between staff regarding the understanding for why forensic clients might engage in self-harm.
- 2) Can consensus be reached within forensic staff for the helpfulness of management strategies for self-harm in secure wards
- 3) To identify and explore the psychological models and approaches used by psychologists in secure wards with clients who self-harm, and the usefulness of these approaches specifically for working with self-harm.

Method

Design

This study was awarded favourable NHS, local R&D and university ethical approval (Appendix C. and D.).

The study addressed the research aims by using a Delphi consultation survey, a method of data collection which aims to measure diversity of opinions relating to a specified topic, and is often understood as a method for generating consensus amongst its participants (Hasson, Keeney & McKenna., 2000). The Delphi method is extensively used in research as a means to gather data from defined experts (Benton, Gonzalez-Jurado & Beneit-Montesinos, 2013) and through an iterative cycle of questionnaires, experts are able to generate, usually anonymously, clarity and coherence around the issues being explored (Hsu & Sanford, 2007).

As a highly flexible methodology, the Delphi does however remain defined by several key characteristics (see figure 7).

- 1) Participants in the study are included for their particular expertise in the area. Participants are, for this methodology, referred to as 'panellists'.
- 2) The Delphi typically uses two to four rounds of questionnaires (Polit & Beck, 2008), however three rounds is generally felt most appropriate, without feeling excessive to panellists and resulting in low response rates (Linstone & Turoff, 2002).
- 3) Initial exploration of themes and ideas on the topic are explored with the first round of the Delphi questionnaire (R1Q), creating generation of ideas which are pertinent to the topic. This first round typically consists of open ended questions which elicit qualitative data.

- 4) The second round questionnaire (R2Q) is formed from the collated and answers from round one. Typically this forms a series of questions or statements ('tick box' format).
- 5) The final round of the questionnaire invites panellists to revise/ re-rate their answers, by sending the same questionnaire again, however scores from all panellists are presented in this round for each individual panellist's consideration.

Figure 7. Key characteristics defining Delphi methodology

The Delphi method offers some unique advantages to exploring areas of consensus and divergence in opinion. It provides panellists with an anonymous forum to express their views and provide feedback as well as capturing a population spread over a wide geographical area. The survey modality prevents a dominant voice or perspective 'drowning out' other viewpoints, such as might occur in focus groups. A particular strength of the Delphi lies in how panellists are actively involved in the way in which the survey evolves across the three rounds, and thus data produced is thought to increase the acceptance, ownership and credibility of the research findings when considered within the target population (Gibson, 1998). The management of self-harm is an emotive topic, as is inviting staff to comment on their views of patient care, and the method is well suited, therefore, to inviting open and honest reflections on practice.

Participants

Focus Group Members

A focus group was conducted with service users to explore their experiences of self-harm within forensic wards. The focus group comprised of three service users currently resident on a low secure forensic inpatient ward. The ward's Clinical

Psychologist (and research supervisor) identified ward residents with experience of self-harming behaviour, and in consultation with the ward manager as to the appropriateness of inviting these clients to participate, individuals were approached on the ward and the proposed group was explained to them. Those wishing to participate were given participant information sheets and consent was collected (Appendix E and F.). Emphasis on consulting with service users around their experiences and care needs, particularly within forensic services, is gaining more interest in recent years. Coffey (2007) posits that service user input is central to providing balance in their complex care needs, hence the inclusion of the views and strategies of service users as to how to manage self-harm was important include within this study . For this study, during the focus group, service users were asked to identify their positive experiences of self-harm management, and what they felt staff should be prioritised when being cared for. Panellists were then asked, during R2 and R3, how important they considered these elements to be in caring for service users.

Delphi Panellists

Roberts-Davis and Read (2001) advocate the view that when exploring professional views or roles, panellists should be selected from both experienced and less experienced staff members, as both have unique experiences and perspectives on the topic. This study included the following inclusion criteria for panellists: Any professional disciplines currently working on low, medium or high secure forensic inpatient wards (or within the last five years) or persons with extensive research work in the area of managing self-harm in forensic services.

All staff members within the hosting NHS site working in secure and forensic wards received an invitation to participate in the survey, which included staff working in both medium and low secure wards. Conference contacts were also approached by the author and clinical supervisor. Social media sites with relevant professional contacts were also accessed, along with email addresses provided as contact details in relevant research literature. Participants were sent an email explaining the nature of the study, which included a web link to the online survey featuring a participant information sheet (PIS) and consent form (Appendix. G.). If the consent form was completed, panellists could then complete the first round of the questionnaire.

Of those individuals having received the email and survey link, 23 completed both the consent form and the entire survey. Twenty panellists completed round two, and 17 completed round three (see table 7).

Panellist Demographic Information		Round One (n=23)	Round Two (n=20)	Round Three (n=17)
Professional Discipline	Clinical Psychologist	11	9	9
	Forensic Psychologist	3	2	2
	Support Worker	1	1	/
	Mental Health Nurse	4	2	3
	General Nurse	1	3	/
	Occupational Therapist	1	1	1
	Psychiatrist	2	2	2
Security Level of Ward*	Low	8	7	5
	Medium	18	12	12
	High	4	2	3
Years of Relevant Experience	1-3	4	3	2
	4-6	5	4	3
	7+	14	13	12
NHS Agenda for Change Band (<i>if applicable</i>)				
	5	1	1	1
	6	2	2	2
	7	3	2	1

	8a	3	3	3
	8b	4	2	2
	8c	2	2	2
	8d	2	2	2
	Not Applicable	3	2	2
	Prefer not to say	3	3	2
Work with Males or Females	Males Only	8	5	5
	Females Only	9	7	5
	Males and Females	6	8	7

*Some panellists worked across multiple levels of security wards hence higher frequency total

Table 7. Professional disciplines of staff completing each iteration of the questionnaire

Materials

An online survey was constructed using Survey Monkey. QSR NVivo 10 was used to analyse data.

Procedure

The first step of the project was conducting a focus group with service users, which was held on a low secure forensic ward. The focus group was facilitated by the author and a senior member of ward staff. A series of semi-structured questions were asked, and related questions were posed to further explore some answers provided by group members (Appendix H.). This interview was recorded on a digital Dictaphone. The focus group was then transcribed and a Thematic Analysis was used to explore and identify themes within the data to structure round one of the Delphi.

The first round of the Delphi was then constructed using an online survey provider. This consisted of four open-ended questions, and one additional question

only for panellists who were clinical or forensic psychologists. An email including the survey link was then sent to all forensic ward staff within hosting NHS site, and additional conference contacts and research authors identified from relevant literature. Consent and demographic information had to be completed before panellists could complete the survey- to ensure they met requirements of participation and understood the iterative process of the study.

Data from round one was analysed using thematic analysis. For round two, statements were produced into themes, including frequency of management strategies, understanding of self-harm and helpfulness of strategies. Panellists rated agreement of statements on a 1-5 point Likert scale. For statements exploring frequency of practices, a Likert scale was also used (*1: Very Often – 5: Very Rarely*). Six statements were also included from the focus group reflecting practices which service users felt to be important in their care, and panellists were asked to rate the extent to which they felt these were a priority in their work (*1: high priority – 5: Low priority*). Free text responses were also invited. This round of the questionnaire was piloted by two trainee clinical psychologists, one of whom had extensive research experience in conducted the Delphi methodology.

The final round of the Delphi was then sent. This was the same as the second round (with the exception of questions relating to frequency of specific management practices, as this was not an opinion, rather a concrete reflection of practice and hence unlikely to change). However, on this final round, for each statement, the group response rates were indicated, so the panellist could see how other experts had answered (shown as percentages). The answer the panellist provided on round two was also indicated. Panellists were invited to re-rate the statements in light of viewing

other responses, however it was emphasised that there was no expectation or requirement for them to change their answers. Panellists had two weeks to complete this round of the survey, and a reminder was sent after one week. See figure 8 for process flow chart.



Figure 8. Flowchart illustrating Delphi construction and dissemination process

Measures

Round One Questionnaire

Round one consisted of four open ended questions, with one additional question specifically for either Forensic or Clinical Psychologists (see table 8).

Questions for all Panellists	<p>1. What is your understanding of why some clients on forensic inpatient wards might harm themselves?</p> <p>2. What approaches do you use in your current practice to manage clients who self-harm? These might include psychological approaches, security procedures, practical activities.</p> <p>3. In your view, how useful have these approaches been for client and staff teams?</p> <p>4. What are your views on the use of ward procedures for management of self-harm? These may include the use of safe rooms, seclusion, de-escalation suites, physical restraint or direct observation.</p>
Question for Clinical and Forensic Psychologist Panellists only	<p>5. Are there any theoretical models/ approaches which you find particularly helpful in working with clients who self-harm?</p>

Table 8. Open ended questions in round one survey

Round Two and Three Questionnaires

The second round of the Delphi was constructed from round one data having been analysed using Thematic Analysis (as described by Braun & Clarke, 2006) and constructed in line with Oppenheim's principles for designing questionnaires (Oppenheim, 2001). See Appendix H and I for sample transcript thematic coding examples. For all thematic analyses conducted within the study, themes were discussed with the clinical supervisor. Amendments were made to coding structure

and order based on these discussions. The order of questions in round two and three followed the related question topics of round one, however, within these themes, questions were randomised to minimise order effects in responses (Schumann & Presser, 1981). See Appendix M for round1-3 surveys.

Consensus

Von der Gracht (2012), Hasson, Keeney, & McKenna (2000) and Mitchell (1991) state that no definitive levels of consensus have been agreed upon for the purpose of analysing the Delphi method. Iqbal & Pison-Young (2009) however, argue the importance of identifying a pre-determined level of consensus prior to analysis. For this study, consensus was defined as 51% agreement amongst panellists. Additionally, strength of consensus was defined as strong, medium and weak (see table 9).

Consensus Categories	Percentage of Ratings
Strong	>83.3%
Medium	>66.7%
Weak	>50%
No Consensus	≤50

Table 9. Strength of consensus categories

Results

Using the qualitative data collected in round one, a thematic analysis was conducted to identify themes relating to what staff understood as the meanings, motivations or emotions underpinning the act of self-harm carried out by their clients.

These were defined as “Eliciting Staff Response”, “Meaning of Self-harm”, “Client’s Self-Management” and “Diagnostic and Iatrogenic Factors”. The themes identified appear to relate closely to those defined by Gough & Hawkins (2000) which included ‘Underlying Factors’, ‘Feelings Precipitating Self-harm’ and ‘Function served by Self-Harm’.

This section of the survey was analysed to explore research aim one; to identify areas of consensus and divergence between staff’s understandings of why clients in secure and forensic services might engage in self-harming behaviour.

The panellists’ understanding of why clients self-harm will be reported first, under the identified domains of “Eliciting Staff Response”, “Meaning of Self-harm”, “Client’s Self-Management” and “Diagnostic and Iatrogenic Factors”. The following tables will include the final percentage of agreement, neither agree nor disagree, or disagree as collated from round three data, however results from the round two data will also be indicated, to show where consensus may or may not have changed between rounds. The strategies most frequently used will then be presented, and how helpful panellists consider these in their practice (research question two). Finally, the models identified by clinical and forensic psychologists in working with self-harm will be presented, and the elements of these models which panellists felt were particularly helpful when working with self-harm.

Panellists’ understanding of self-harm: Eliciting a Staff Response

Within the domain of ‘eliciting a staff response’, the only strong consensus was that clients self-harm to communicate to staff that which they are unable to speak,

reaching 100 % agreement. 76.5 % and 70.6 % of panellists disagreed with statements describing motivation for self-harm as to avoid prison transfer or to manipulate staff/ gain attention- showing medium strength consensus. No consensus was achieved regarding clients self-harming to avoid discharge into the community (see table 10). Slight changes in responding were noted between round two and three, however these did not alter the majority consensus.

Survey Items 1- 5	Agree %	Neither Agree nor Disagree %	Disagree %
Strong Consensus			
To communicate to staff their distressing feelings which they struggles to verbalise	100 (100)	0 (0)	0 (0)
Medium Consensus			
Clients self-harm to avoid transfer to prison	5.9 (15)	17.6 (20)	76.5 (65)
Clients self-harm to manipulate staff and gain attention	23.5 (25)	5.9 (10)	70.6 (65)
Weak Consensus			
Clients self-harm in the hope of leaving the ward	17.6 (30)	23.5 (25)	56.4 (45)
No Consensus			
Clients self-harm to avoid discharge into the community	47.1 (40)	23.5 (30)	29.4 (30)

Table 10. Consensus ratings for staff understanding of self-harm: Eliciting a staff response. Percentage in bracket shows round two result.

Panellists' understanding of self-harm: Meaning of the Act

There was strong agreement reached regarding the meaning of the act of self-harm (see table 11). Communication of internal world, experiences of complex trauma and managing distress showed 100% consensus. Panellists showed strong consensus that clients self-harm to gain some control of their feelings, and issues such as low self-esteem, poor coping skills and expression of internalised anger additionally elicited strong consensus of agreement. A weak consensus was achieved regarding self-harm as a means to attack the relationships developed with staff. Consensus was

not achieved concerning the aim of self-harm to de-sexualise the client's body, and interestingly no consensus was reached for the statement specifying self-harm as an act indicating the client's desire to end their life. Again, slight changes were observed between rounds two and three, but majority consensus was not changed.

Survey Items 7-18	Agree %	Neither Agree nor Disagree %	Disagree %
Strong Consensus			
Clients self-harm as a communication of their internal world	100 (95)	0 (5)	0
Clients self-harm due to experiences of complex trauma	100 (90)	0 (10)	0
Clients self-harm as a way of managing and controlling their distress	100 (90)	0 (5)	0 (5)
Clients self-harm in response to a current event (e.g. family difficulties, leave changes etc.)	100 (100)	0 (0)	0 (0)
Clients self-harm due to the intensity of their distressing feelings	100(100)	0 (0)	0 (0)
Clients self-harm in an attempt to gain some control of their feelings	94.1 (85)	0 (10)	5.9 (5)
Clients self-harm due to feelings of low self-esteem	94.1 (85)	0(15)	5.9
Clients self-harm due to poor coping skills	94.1 (90)	0 (5)	5.9 (5)
Clients self-harm as an act of internalised anger, rather than harming others	88.2 (80)	11.8 (20)	0 (0)
Weak Consensus			
Clients self-harm as an attack on the relationships developed with staff	58.9 (55)	41.2(35)	5.9 (10)
No Consensus			
Clients self-harm as a means of 'de-sexualising' their bodies in response to abuse experiences	41.2 (50)	47.1 (35)	11.8 (15)
Clients self-harm because they wish to end their life	11.8 (20)	47.1 (45)	41.2 (35)

Table 11. Consensus ratings for staff understanding of self-harm: Meaning of the Act. Percentage in bracket shows round two result

Panellists' understanding of self-harm: Clients' Self-Management

All statements explaining self-harm as a means of clients managing their internal or emotional states reached consensus between panellists. Statements exploring self-harm as a clients' way of managing their feelings of distress, as a means to escape emotional numbness, and as a means of self-punishment showed a high level of consensus. A medium level of consensus was achieved for self-harm being used to soothe emotional pain and because of the client's poor impulse control. A weak level of consensus was achieved for the statement that clients harm themselves because they are 'addicted' (see table 12). Although some changes in responding were shown between rounds two and three, the majority consensus did not change.

Survey Items 20-26	Agree %	Neither Agree nor Disagree %	Disagree %
Strong Consensus			
Clients self-harm as a way to manage distressing thoughts and feelings	100 (95)	0 (5)	0 (0)
Clients self-harm as an attempt to escape feelings of numbness	94.1 (88.8)	5.9 (11.1)	0 (0)
Clients use self-harm as a distraction from emotional pain	94.1 (88.8)	5.9 (11.1)	0 (0)
Clients self-harm as a means of self-punishment	88.2 (77.8)	11.8 (16.7)	0 (5.6)
Medium Consensus			
Clients use the physical pain of self-harm as a means to soothe emotional pain	82.4 (66.7)	11.8 (33.3)	0 (0)
Clients self-harm due to poor impulse control	70.6 (77.8)	23.5 (16.7)	5.9 (11.1)
Weak Consensus			
Clients self-harm because they are addicted to the act	58.8 (49.9)	29.4 (44.4)	11.8 (5.6)

Table 12. Consensus ratings for staff understanding of self-harm: Client's self-management. Percentage in bracket shows round two result.

Panellists' understanding of self-harm: Diagnostic and Iatrogenic Factors

Regarding self-harm as a product of diagnosis ('*severe mental illness*' or '*personality disorder*') a medium level of consensus of *disagreement* was achieved. '*Gaining a sense of identity*', '*copying other ward residents*' and 'as a reaction to incarceration' showed a weak consensus of agreement (see table 13).

Survey Items 28-32	Agree %	Neither Agree nor Disagree %	Disagree %
Medium Consensus			
Clients self-harm because they have a severe mental illness	0 (16.7)	23.5 (22.2)	76.5 (61.1)
Clients self-harm because they have a diagnosis of Personality Disorder	5.9 (16.7)	17.6 (22.2)	73.5 (61.1)
Weak Consensus			
Clients can gain a sense of identity and belonging as a person who self-harms	64.7 (44.5)	29.4 (38.9)	5.9 (16.7)
Clients can self-harm to copy other ward residents	64.7 (55.6)	17.6 (22.2)	17.6 (22.2)
Clients self-harm as a reaction against their incarceration on the ward	29.4 (38.9)	52.9 (44.4)	17.6 (22.2)

Table 13. Consensus ratings for staff understanding of self-harm: Diagnostic and Iatrogenic Factors. Percentage in bracket shows round two result.

Research Aim Two: What management strategies are used by staff and how helpful do they consider these to be in their practice?

Research aim two aimed to explore areas of consensus and divergence regarding what strategies are used by panellists to manage self-harm and how helpful panellists considered these approaches in their practice on secure wards. From the strategies outlined as being used by panellists in round one, round two and three asked panellists to rate their views on how helpful they considered these strategies to be in managing clients who self-harm. Of the strategies identified, these were broken down into three categories; relational, procedural and physical management strategies.

All management strategies listed in round one were collated and clustered into the three domains for SAFS which mapped onto the levels of security required in secure services; relational, procedural and physical strategies. In R2 all participants were asked to rate how often they implemented these strategies in their practice. Given that frequency of practice was not considered likely to change or face amendment as part of the Delphi process, these questions were not repeated in R3. Regarding strategies mapped on to physical security procedures, 64 % of panellists reported using these strategies '*very often*' or '*often*', with 19% using physical security procedures '*rarely*' or '*very rarely*'. Procedural based management strategies such as reviewing medication or transferring the client showed a response rate of 30% for '*very often*' and 33% for '*often*' - compared to 6% for '*rarely*' and 3% for '*very rarely*'.

Sixty-three percent of panellists report relational based self-harm management strategies as ‘*very often*’ and ‘*often*’ in their practice, with only 15% stating they utilised these approaches ‘*rarely*’ or ‘*very rarely*’ (see table 14).

Strategy Approach Category	Very Often or Often	Neither	Very Rarely or Rarely
Physical	64%	16%	19%
Relational	63%	28%	9%
Procedural	59%	26%	15%

Table 14. Panellists reported frequency of strategies used to manage self-harm by approach category

None of the management strategies falling into the category of ‘physical security’ showed a strong consensus as being helpful in managing self-harm (see table 15). A medium level of consensus was reached for the helpfulness of strategies such as de-escalation suites, staff observation and room searches. There was a medium level of consensus that using physical restraint to manage self-harm was *not helpful*, and consensus could not be reached as to whether preventing access to a client’s bedroom is helpful. Interestingly, panellists reported physical management strategies as most frequently employed in their practice (64% indicating ‘often’ or ‘very often’) however, medium consensus was achieved that practices such as physical restraint and use of seclusion were felt to be *unhelpful* management strategies. Given that physical management strategies were reported as most frequently used then, it is interesting that no high level of consensus was reached for the helpfulness of these approaches; two practices were felt to be unhelpful approaches, and no consensus could be reached regarding how helpful it is to remove a client from their bedroom during an incident of self-harm.

Survey Items 34-42	Helpful	Neither Agree nor Disagree %	Not Helpful
Medium Consensus			
Use of de-escalation suite	75 (76.5)	25 (23.5)	0 (0)
Implement/ Increase staff observation	75 (64.7)	12.5 (17.7)	12.5 (17.7)
Removal of risk item (e.g. an item a client is using to harm themselves with)	68.8 (70.6)	12.5 (11.8)	18.6 (17.7)
Room searches	62.5 (58.9)	18.8 (23.5)	18.8 (17.7)
Restriction of access to ward leave	12.5 (17.7)	62.5 (52.9)	25 (29.4)
Physical restraint	18.8 (23.5)	18.8 (23.5)	62.5 (52.9)
Weak Consensus			
Use of safe rooms (e.g. empty bedroom, rather than client accessing own room)	56.3 (52.9)	37.5 (35.3)	6.25 (11.8)
Use of seclusion area	25 (23.5)	18.8 (23.5)	56.3 (52.3)
No Consensus			
Preventing client access to their bedroom	25 (23.5)	43.8 (23.5)	31.3 (52.91)

Table 15. Consensus ratings of helpfulness of strategies to manage self-harm: physical measures. Percentage in bracket shows round two result.

Within strategies felt to reflect the relational elements of managing self-harm, panellists were in 100% agreement that staff teams receiving regular supervision and support is helpful in managing self-harm. Strong consensus was also achieved that *‘providing one-to-one time’* (including after a client has self-harmed) and *‘encouraging client to attend peer support/ reflective groups’* are both helpful management strategies. Using harm minimisation strategies drew a medium level of consensus. *‘Minimal staff intervention is provided during self-harm episode’* received a 75% response rate of *‘neither helpful nor unhelpful’* and hence consensus was not achieved for this item (see table 16).

Survey Items	Helpful	Neither Agree nor Disagree %	Not Helpful
Strong Consensus			
Staff team receives on going support and supervision around the management of clients who self-harm	100 (100)	0 (0)	0 (0)
1:1 time provided specifically with client's Primary Nurse	100 (82.4)	0 (17.7)	0 (0)

1:1 time offered by ward staff after client has harmed themselves	93.8 (82.4)	0 (11.8)	6.3 (5.9)
Providing or encouraging attendance of client reflective groups/ peer support group work	93.8 (88.2)	6.3 (11.8)	0
Medium Consensus			
Provision of harm-minimisation strategies (e.g. holding ice cubes, 'theatre blood', etc.)	81.3 (58.8)	18.8 (35.3)	0 (5.9)
Minimal staff interaction is provided during self-harm episode	25 (29.4)	75 (58.8)	0 (11.8)

Table 16. Consensus ratings of helpfulness of strategies to manage self-harm: relational measures. Percentage in bracket shows round two result.

Of the six statements asking panellists to rate helpfulness of procedural management strategies, three received high consensus of agreement; implementing contingency plan and reviewing client risk-assessment and overall care (see table 17). Medium level of consensus was reached that assessing severity of harm to inform level of staff intervention was helpful. Transferring client to A&E and reviewing medication received majority neutral 'neither helpful nor unhelpful' responses, indicating consensus could not be achieved for the helpfulness of these strategies.

Survey Items	Agree %	Neither Agree nor Disagree %	Disagree %
Strong Consensus			
Implement contingency plan for client regarding self-harm	100 (94.1)	0(5.9)	0 (0)
Review of client risk assessment	93.8 (100)	6.3 (0)	0 (0)
Review of client care (e.g. consider referrals that may be required such as Autism assessment, anger management work, etc.)	93.8 (88.23)	6.3 (11.8)	0 (0)
Medium Consensus			
Assess severity of harm caused, and use this to inform level of staff intervention required	81.3 (76.5)	18.8 (23.5)	0 (0)
Transfer client to general hospital/ accident and emergency department	18.8 (23.5)	75 (47.1)	6.3 (29.4)
Weak Consensus			
Review medication	31.3 (29.4)	56.3 (47.1)	18.8 (23.5)

Table 17. Consensus ratings of helpfulness of strategies to manage self-harm: procedural strategies. Percentage in bracket shows round two result

Strategies felt to be most helpful to service users participating in the focus group were also presented and panellists asked to rate the level of priority they consider these for their practice. Interestingly, five of the seven statements received 100 percent consensus for these practices being 'high priority' in their work. Service user's spoke of wishing to have incidents of self-harm managed in their bedrooms, both for themselves and for others (so residents do not have to see the injuries of their peers) and panellists showed a medium consensus for this being a priority in their management approach (see table 18).

Survey Items 58-64	Agree %	Neither Agree nor Disagree %	Disagree %
Strong Consensus			
Listening to the client's explanation and understanding of their self-harm	100 (88.2)	0 (11.8)	0 (0)
Maintaining a non-judgemental approach to clients who have harmed themselves	100 (100)	0 (0)	0 (0)
Maintaining an empathetic approach to clients who have harmed themselves	100 (100)	0 (0)	0 (0)
Ensuring support is offered to clients when they have been removed from their bedrooms	100 (88.2)	0 (5.8)	0 (5.8)
Being aware of the individual risk and care plans for clients who self-harm, and the individual reasons for which a client may harm themselves	100 (100)	0 (0)	0 (0)
Where possible, to make a client's bedroom safe, rather than moving them to a safe room or seclusion	93.8 (88.2)	0 (5.8)	6.3 (5.8)
Medium Consensus			
If possible, managing self-harm wounds in client bedroom to avoid other ward residents seeing injuries in communal areas (assuming incident occurred in the client's bedroom)	81.3 (76.5)	18.8 (23.5)	0 (0)

Table 18. Consensus of priority of helpful management strategies identified by service users in focus group

For all of the above domains, slight changes in panellist's responses were observed between round two and three, however these did not alter the overall consensus between the rounds.

Research Aim Three: Psychological Models and Theories for Managing Self-Harm

Research aim three aimed to explore the models and approaches used exclusively by clinical and forensic psychologists within the Delphi panellists, and the reasons why such approaches were used to work with self-harm. A thematic analysis was conducted on this data from the Delphi, to identify common themes on what is effective in managing clients who self-harm, with particular emphasis on psychological approaches. Although not a common practice with Delphi consultation data, it is noted within the literature that providing additional analysis methodology can provide versatility and dramatize research designs (Sandelowski, 2000). Kennedy (2004) advocates the use of thematic analysis to further explore Delphi data, providing an additional dimension of validity to the results and providing "*further inquiry to enhance and support Delphi findings*".

Round two asked psychologists to provide qualitative comments on which approaches they currently use, and what elements of these approaches they considered to be useful in working specifically with clients who self-harm. See table 19.

Psychological Model or Approach	Number of Panellists Using Approach in Practice (n=9)
Focus on Therapeutic Relationship	8
Cognitive Behavioural Therapy (CBT)	7

Narrative Therapy	7
Mentalization Based Therapy (MBT)	7
Mindfulness	7
Dialectical Behaviour Therapy (DBT)	6
Recovery Focused Work	6
Trauma Focused Work	6
Psychodynamic Work	5
Eye Movement De-sensitization and Reprocessing (EMDR)	5
Compassion Focused Therapy (CFT)	4
Schema Therapy	4
Systems Training for Emotional Predictability and Problem Solving (STEPPS)	4
Acceptance and Commitment Therapy (ACT)	2

Table 19. Psychological models or approaches listed by psychologist panellists as used in their practice with clients who self-harm

A thematic analysis was conducted to explore the common themes, throughout the above approaches, that clinical and forensic psychologists found useful in their work with clients who self-harm. Five leading themes were identified;

- i. Emphasis on Client Emotions
- ii. Developing New Skills
- iii. Positive focus of approach
- iv. Practical Strengths of approach
- v. Emphasis on relational working

Examples of quotations within each theme are listed below in table 20.

Theme Identified	Emphasis on Client Emotions	<p><i>“Yes, we use this for second stage work during the pathway of care once the patients have got a handle on their urges to self harm. MBT is vital for relationship and emotional awareness”.</i> (MBT)</p> <p><i>“Management of emotional arousal”</i> (DBT)</p> <p><i>“Important in teaching self-compassion and exploring deficits in Gilbert's 3 self-regulation sub-systems.”</i> (CFT)</p> <p><i>“Helpful to help people in a compassionate and no stigmatised way to cope with the way they are feeling”.</i> (CFT)</p> <p><i>“Helpful to help people in a compassionate and no stigmatised way to cope with the way they are feeling. And increase openness to experience and psychological flexibility. Works well as learning can be generalised and applied to all areas of their life and experiences”.</i> (ACT)</p>
	Developing New Skills	<p><i>“Can be useful as part of a wider therapeutic relationship - e.g, teaching people how to challenge automatic negative thoughts and encouraging positive self-talk”.</i> (CBT)</p> <p><i>“Psycho-educational, provide coping strategies, provide emotional 'language' to experiences”.</i> (STEPPS)</p> <p><i>“Good as a first strategy to develop concrete coping skills, either in isolation or before starting deeper work”.</i> (STEPPS)</p>

		<p><i>"..'here and now' tools to cope".</i> (CBT)</p> <p><i>"I use this less with complex cases - some of the psycho-education around mood management, coping etc. may be helpful".</i> (CBT)</p> <p><i>"Self-harm can be formulated as a break-down in mentalisation; developing mentalisation skills can increase availability of alternative options such as verbalising emotional pain".</i> (MBT)</p>
	Positive Focus of Work	<p><i>"...support from other service users, learnt expertise from the person themselves".</i></p> <p><i>"Very collaborative and respectful, and allows people to manage their own experiences in the context of what they learn".</i> (CFT)</p> <p><i>"Helps people to build on strengths rather than address problems".</i> (Recovery focused work)</p> <p><i>"Gives a more positive focus and helps clients imagine that there might be a future- also allows for a discussion about what recovery means, and how some level of self- harm may continue and how this can be managed".</i> (Recovery Focused work)</p> <p><i>"Non threatening and non oppressive. Helps people to build on strengths rather than address problems. Empowering. In my experience has very good results".</i> (Narrative Therapy)</p>

	Practical Qualities of Approach	<p><i>"...also good for complex cases as people can repeat modules until they have got to grips with things".</i> (DBT)</p> <p><i>"To address trauma in clients who cannot do this via other therapeutic means eg cbt".</i> (EMDR)</p> <p><i>"Works well as learning can be generalised and applied to all areas of their life and experience".</i> (ACT)</p> <p><i>"Also important systemically to show a holistic understanding of their current difficulties".</i> (Trauma focused work)</p> <p><i>"Helpful to formulate simply".</i> (Narrative Therapy)</p> <p><i>"Helpful for a practical focus on specific problems".</i> (Narrative Therapy)</p> <p><i>"Yes, drawing attention to the mind, breathing, the body all a useful foundation for de-stressing the person".</i> (Mindfulness)</p> <p><i>"Very useful for developing a shared formulation, understanding patterns of behaviour".</i> (Schema Therapy)</p>
	Relational Emphasis of Approach	<p><i>"I often use this to help the client feel heard when they have never been listened to".</i> (Narrative Therapy)</p> <p><i>"I very much like this for the potential to script/re-script a damaged identity and lift self-esteem by shining light on the story that has not been told about the person".</i></p>

		<p>(Narrative Therapy)</p> <p><i>“...helps with formulation of unconscious factors and to be aware of transference in the room”.</i></p> <p>(Psychodynamic approach)</p> <p><i>“Can be helpful to formulate counter-transferential responses, but NOT if applied in a judgemental (we know better than you are about your impulses) kind of style”.</i></p> <p>(Psychodynamic Approach)</p> <p><i>“Very useful staged approach that also tackles client resistance and therapy interfering behaviour”.</i></p> <p>(DBT)</p> <p><i>“Absolutely vital. A lot of clients feel a lot of shame and this can lead to 'resistance'. It is the therapist's job, not the clients to accommodate this”.</i></p> <p>(Therapeutic relationship)</p> <p><i>“Increases relational security, sense of collaboration, opportunity to risk assess and care plan together”.</i></p> <p>(Therapeutic relationship)</p>
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Table 20. Helpful qualities of psychological approaches for working with self-harm from thematic analysis

The qualities of psychological models and approaches understandably map closely onto the very elements that define the models. What remains interesting, then, is how clinicians conceptualise broad models for their usefulness with working specifically for clients who self-harm. DBT, often referred to as the ‘gold standard model’ for working with clients with a diagnosis of Borderline Personality Disorder, has strengths in its focus on emotion regulation work. Interestingly, within the theme of ‘emphasis on client emotion’, panellists drew on the usefulness of compassion based approaches for managing emotions also. Emotional awareness is also listed as a key within this theme- with a panellist explaining the efficacy of MBT for providing such a skill.

Of the nine panellists, eight commented on the ‘therapeutic relationship’ as an approach of their work. Given that these panellists are psychologists, emphasis on the therapeutic relationship is not surprising, however specific models were highlighted as being useful for their emphasis on this approach, such as Narrative Therapy and Psychodynamic working. The role of relational security is also directly commented on as a helpful element of focusing on the therapeutic relationship (*“Increases relational security, sense of collaboration, opportunity to risk assess and care plan together”*)- addressing the underlying roles of security which underpin work in secure forensic units.

‘Positive focus of approach’ was a theme which encompassed elements of many of the models listed. Aspects of models within this theme reflected on qualities such as empowerment, collaboration, strengths-focus and accessing the “learnt experience” of the client. Qualities of models in this theme included collaboration and empowerment. Approaches listed also appeared to reflect strength for their practical qualities, such as providing a holistic understanding of difficulties (trauma focused work), helpfulness of

providing focus on specific problems (narrative therapy) and usefulness of developing a shared formulation (schema therapy).

Acknowledgement of the limitations of some models of psychological intervention when working with clients who self-harm were also addressed by panellists. CBT reflected mixed views for its efficacy in working particularly with self-harm: *“I use little bits for depression/ panic/psychosis symptoms etc. but not directly to work with self harm”... “Can be helpful for minor issues or to inform brief interventions, but I can find the diagnosis specific models oppressive for clients. Very problem focussed”*. Panellists additionally reflected on how different models suite different clients, *“Marmite! Works brilliantly for some clients while others hate it”*, (referencing Mindfulness approaches). Panellists indicated that trauma-focused work can be useful, however this can be limited for some clients: *“Usually important but I have sometimes deliberately not done this as this client does not have the ego strength to manage it”*; *“To address underlying cause but only when client is stable enough”*.

Discussion

Little evidence exists in the literature regarding how self-harm is managed across low, medium and high secure forensic units. Managing clients who self-harm in secure units is viewed as particularly challenging, given the increased risk of self-harm acts in secure wards, the higher level of violence directed towards staff treating individuals who self-harm, and the tendency for self-harm to be carried out in secret within these service (Sarkar &

Beeley, 2011). NICE guidelines for longer term management of self-harm cannot capture the challenges faced within secure wards, and given the levels of security which are mandatory for secure units (RCP; Standards for medium secure units, 2012) the clinical complexities in caring for clients who self-harm are significant.

This study aimed to explore what management strategies are employed by staff working in low, medium and high secure units in the UK, how frequently staff use these practices and how effective staff consider these to be in their work with clients who self-harm. The Delphi methodology was employed to measure rates of consensus amongst panellists on the above questions

Strategies identified for managing self-harm were clustered into relational, procedural and physical measures- reflecting the three levels of security required of secure forensic wards. Panellists reported using physical management strategies most frequently, closely followed by relational and then procedural methods. Gallagher and Sheldon (2010) reported on how staff managed incidents of self-harm on a high secure ward, and of the six responses outlined, also found that physical measures were most frequently implemented (e.g. increasing staff observations, using quiet rooms and ‘applying safety restrictions’).

Panellists were also required to rate how helpful they found the outlined management strategies to their practice. Relational strategies, such as providing 1:1 time, talking with primary nurse and staff receiving supervision showed strong consensus of agreement across the domain, more so than physical or procedural techniques (however there was only slight variations in rates of practice). Given that consensus was reached in disagreement for the helpfulness of physical restraint and use of seclusion area, it is perhaps unusual that physical

management strategies are reported as most frequently employed by panellists. Sandy and Shaw (2012) also reported that physical measures were reported as most frequently used by staff in secure services (staff observations), and staff reported their tendency to apply ‘rigid-authoritative’ or ‘blanket’ management approaches to all clients who self-harm whilst recognising that these approaches were ultimately detrimental to their relationships with clients.

The ways in which panellists understood the act of self-harm were divided into four domains; ‘eliciting staff response’, ‘meaning of the act’, ‘client self-management’ and ‘diagnostic and iatrogenic factors’. Within the category of ‘eliciting staff response’, a one hundred percent consensus of agreement was achieved for clients self-harming as a means to communicate to staff feelings which they cannot verbalise. Statements reflecting negative views of clients who self-harm (e.g. ‘to manipulate staff and gain attention’ or ‘to avoid transfer to prison’) received medium strength consensus of *disagreement*, meaning that the panellists felt such outcomes/ staff responses were not reasons for which their clients self-harm. Negative attributions for the reasons why clients self-harm are noted throughout the literature (Gough, 2005, Wheatley & Austin Payne, 2009; Sandy and Shaw, 2012) and whereas this study identified such beliefs from panellists (during round one analysis), overall consensus was achieved that such negative views do not underpin the act of self-harm.

Statements attempting to explain the meaning of self-harm for clients showed high consensus across several statements which explain self-harm as a communication of the client’s internal world, as related to experiences of complex trauma, as due to the intensity of distressing feelings, because of poor coping skills and feelings of low self-esteem. One hundred percent consensus was found that clients self-harm as an act of communicating their

internal world, supporting the view of Motz (2009) who presents self-harm as an act of communication as the central hypothesis for understanding the act. Campbell and Hale (1991) describe the communicative act of self-harm as an “attack on the minds of others- testing the capacity of the other to tolerate distress which cannot be managed by the individual. It is therefore the role of the staff member to receive this communication, bear the distress, and facilitate alternative ways of the client to express their powerful feelings.

Strong consensus was achieved regarding management and control of distress as a reason for self-harm. Potentially conceptualised as a hopeful act, Winnicott (1956) describes the hope inherent in an antisocial act, whereby the individual tests their environment to assess its ability to withstand aggression, to repair this destruction and to tolerate the “nuisance”. Motz (2009) applies this theory to self-harm, whereby the body becomes the environment to be tested and repaired- and through tolerating this process, a person can defeat the internal fear of their destructive capacity and psychically “survive” the assault. Strong consensus of agreement for the role of self-harm as controlling distress was reached, and this too appears to reflect some understanding that intolerable feelings are expressed/ communicated in an attempt to survive and reach a state of internal homeostasis.

Controlling difficult feelings, expression of internalised anger, experiences of complex trauma and managing distress all reached high consensus of agreement, and perhaps speak to the theories of defence mechanisms described by Klein (1946). Klein (1946) explains the ‘splitting process’ of the early infant who, unable to tolerate both the good and bad elements of her mother, projects these ‘bad’ feelings outside of herself, as they are experienced as intolerable. It is argued, therefore, that self-harm in the adult re-visits such a defence, with the dangerous and intolerable internal state being projected outwards onto the

body. By both attacking the body, and nurturing her wounds, the client who self-harms can modulate between the two split selves of victim and aggressor. Motz (2009) posits that the role of therapist then, should be to contain both the positive and negative feelings of the client- and foster the client's. Birch et al. (2011) argue that rates of adverse childhood experiences are high for clients within forensic services, and suggest, perhaps an increased likelihood of such primitive defence mechanisms being present for clients in forensic services.

A high level of consensus was reached for statements explaining self-harm as an act to 'to escape feelings of numbness', 'to escape emotional pain' and to 'distract from emotional pain', as well as 'a means of self-punishment'. The affect-regulation model of self-harm provides support for these views, theorising that self-harm is a management strategy used by the individual to alleviate negative affect or distressing rates of arousal (Favazza, 1992; Gratz, 2003). Linehan (1993) describes how neglectful early environments can provide the individual with unhelpful strategies for managing emotional distress. In this way, self-harm becomes a "maladaptive affect-regulation strategy" for the individual who is unable to otherwise manage their distress. Staff agreement that self-harm can provide a counter to feelings of numbness is supported by theories linking self-harm with dissociation and depersonalization. Gunderson (1984) describes self-harm as interrupting the dissociative episode and regaining a sense of self, through generating emotional and physical sensations which draw the individual into the present; to themselves feel real again. Klonsky (2007) conducted a review of the literature exploring the functions of self-harm and found that affect regulation was most commonly reported function of the act, commenting that negative affect prior to self-harm was frequently reported, followed by a decrease in such strong emotions following the self-harm act. Klonsky (2007) additionally found strong evidence within the

literature for the role of self-punishment in the self-harming act, a view reflected within this study, as panellists showed strong agreement that this was a function for why their clients harmed themselves.

The role of aggression is also conceptualised as significant to self-harming behaviours, and panellists showed strong agreement for internalised anger and self-punishment playing a role in self-harm. This might serve some support to Mannion's (2008) arguments for the way in which aggression, previously expressed towards others when in the community, becomes self-directed by the detained forensic client- offering one's own body as the only viable medium to express such feelings. Linehan (1993) hypothesises that early experiences of punitive and neglectful environments are common for people who self-harm (arguably even more so within secure forensic services) and hence the act of self-harm can be a recapitulation of the anger and self-derogation experienced in such early environments. Klonksy (2007b) thus explains how hurting oneself, given such adverse early experiences, can become ego-syntonic and familiar, and hence become a coping strategy for emotional pain.

High levels of consensus was achieved across many domains of the Delphi highlighting the different reasons which underpin the act of self-harm. Agreement on issues relating to self-harm such as poor coping skills, experiences of complex trauma, feelings of anger, communication of internal world, gaining control, self-punishment and distraction from emotional pain were themes also themes identified by forensic ward staff in the survey conducted by Gough (2000). The present study, therefore demonstrates that the

understanding staff have for self-harm may be similar to previous studies, but unlike other studies, presents high consensus of agreement that such factors are not felt to be a significant function of the act of self-harm. Negative staff attributions towards clients who self-harm are commonly reported within the literature (Sandy & Shaw, 2012; Wheatley & Austin-Payne, 2009; Gough, 2000). Terms such as ‘manipulative’ and ‘attention seeking’ appear frequently in the literature reflecting staff views of clients who self-harm (Sandy & Shaw, 2012), particularly within nursing cohorts. Interestingly, unlike previous studies, when presented with negative statements explaining the act of self-harm (e.g. ‘clients self-harm to manipulate staff and gain attention’ and ‘clients self-harm to avoid transfer to prison’) panellists showed a medium level of disagreement with the statements.

Interestingly, no consensus was reached for the explanation of self-harm as a desire for the person to end their life. This remains a complex and contentious issue within secure and forensic services, which may explain staff’s reticence to either agree or disagree with the statement. It is, however, acknowledged that the ambivalence experienced by some clients regarding dying from, or surviving the act of self-harm, varies significantly and is too varied and complex a theory to be captured in a single statement. This may also reflect the pattern across the literature in differentiating between self-harm and suicidality, and the need to explore further the meaning of the act for the individual to best tailor the management strategy implemented. Suyemoto (1998) theorises that self-harm can communicate the distress and strength of desire to end one’s life, without causing significant harm which might result in death. Himber (1994) theorised that the act of self-harm can ‘stave-off’ suicidal thoughts and actions, acting to prevent the unmanageable build up of distress which might result in more significant harm being carried out.

Research Question two asked panellists to rate the frequency of either relational, physical or procedural management strategies, and how helpful they found these approaches in their work. Physical management strategies were reported as most frequently implemented, however no strong consensus was achieved for the helpfulness of such practices, and conversely strategies such as physical restraint achieved consensus as being unhelpful in client care. The high-stress of forensic inpatient environments is understood to have a significant impact of staff burnout, and Ewers, Bradsahw & McGovern (2002) comment that this will likely have a negative impact on the quality of care provided within such services. Perhaps then, as seen within this study, staff are able to acknowledge the value and positivity of relational management strategies, but given time of high-stress or potential burnout, the manualised, physical-based management interventions are more commonly turned to.

It appears that the management strategies elicited from feedback from service users in the focus group reflect practices typically identified within the 'relational' approach (for example use of empathy and non-judgmental practice). These themes were elicited from a thematic analysis of a focus group with low-secure forensic service users who were asked to discuss what they felt were their most supportive experiences of staff managing their self-harming incidents, and hence what they felt should be the priorities of staff members working with clients who self-harm. The needs identified by service users, such as empathy and a non-judgemental approach, as well as being allowed to explain their reasons for self-harming, all received 100% consensus from panellists. This again, perhaps adds a sense of disparity around useful management strategies, as physical approaches remained most frequently utilised by staff- indicating a schism between what service users feel is most helpful, and what type of care is provided.

Research question three asked panellists who were clinical or forensic psychologists to describe the psychological models or approaches they used in their work with clients who self-harm, and what elements of these models were of particular use for this client group. Fourteen approaches were outlined, with ‘emphasis on therapeutic relationship’, CBT, MBT, Narrative Therapy and Mindfulness being the approaches most frequently referenced by panellists as used in their psychological work. A thematic analysis was conducted on panellists’ responses of the indicated approaches identified as useful in working with clients who self-harm. NICE (2012) guidelines on the longer-term management of self-harm provide clinical recommendations on the psychological interventions to be provided to clients who self-harm. These guidelines are critiqued for their lack of representation of forensic services (Sarkar, 2011), and for their somewhat ‘vague’ applications to practice. Between three to twelve sessions of a psychological intervention that is “*specifically structured for people who self-harm*” are advocated for within the guidelines, however it is acknowledged that robust studies exploring psychological approaches at managing self-harm are lacking. The above analysis, therefore, highlights (within this sample) which models and approaches clinicians feel are most effective in their practice, specifically for self-harm, and what qualities within these model make them particularly relevant to this client population. NICE guidelines additionally stipulate that: “*The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements*” (NICE, 2012), elements reflected in the list of models collated from panellists.

The variety of models and approaches used by psychologists in the Delphi consultation, along with how these are felt to be useful to working with clients who self-

harm, and acknowledgement of their limitations provides a useful dimension to the exploration of how to psychologically work with clients who self-harm. Although 14 psychological approaches were outlined, responses appear to reflect clinician's flexibility in applying these models, perhaps selecting elements of the models which they feel most suit their clients who experience self-harm.

Clinical Implications

Management strategies underpinned by relational processes (e.g. providing one to one time with client, encouraging attendance of client reflective groups and providing on-going support and supervision) were agreed upon as helpful management approaches. Provision of consistent staff support and training related to working with self-harm is therefore important in clinical practice, potentially focusing specifically on the relational challenges faced for staff directly managing clients who harm themselves. Secure wards should aim to maintain open dialogue amongst all staff disciplines and levels of seniority regarding the most useful ways to balance security requirements, with the need to emphasise development of therapeutic relationships with clients.

Certain management strategies were felt to be specifically unhelpful to managing clients who self-harm, such as physical restraint, however physical strategies were reported as most frequently used. The disparity between what staff consider as helpful to managing self-harm, and what may in practice be practiced warrants exploration across wards, to ensure that rigid approaches are not applied to the client group, and ensure staff do not feel pulled towards management strategies which they feel to be unhelpful but are perhaps considered part of standard ward practice. Research has also indicated that burnout can lead to what

Maslach & Jackson (1982) refer to as a “harmful milieu”, whereby staff are less able to show empathy towards clients- which in the forensic population, may link with implementation of more emotionally detached management strategies. Ewers, Bradshaw & McGovern (2002) found that brief psychosocial intervention with forensic mental health staff showed an increase in both knowledge and skills regarding the client group, and compared to a control group, lower levels of burnout were observed over a 12 month period. Consideration of such psychologically informed staff support interventions may therefore be viewed as pivotal to staff working in forensic services, potentially as part of mandatory training across disciplines.

Research on the management of self-harm in forensic settings often tends to reflect staff views that self-harm ‘distracts’ staff from their job role, and is in some way an inconvenience which limits their caring capacities. Perhaps what needs more emphasis in clinical practice in forensic services, is in fact the *centrality* of self-harm management to the role. Rather than being seen as something which prevents staff from effectively caring for their clients, management of self-harm can be seen as an opportunity to explore with clients the nature of their distress and to develop the relational boundaries, which can in turn provide staff with the best knowledge and understanding of how to care for their clients, rather than preventing such a process.

The Delphi method is based on social constructionist epistemology, meaning that individuals create their views and understanding of the world in relation to other people (hence the Delphi method showing panellists the responses of other people). Slight changes to responses rates were observed between R2 and R3, though majority consensus was not altered. This may indicate the strength of beliefs held within this sample, but may also speak to the role of sharing voices and perspectives in mental health work. Several panellists

commented on the usefulness of seeing their views compared to other colleagues, and may provide some evidence for the usefulness of peer and colleague support within clinical settings.

Limitations

Although no required sample size is stipulated in the Delphi methodology, this study utilised a small number of experts. High, medium and low secure ward staff participated in the study, and although these encompass all security levels of SAFS, given the significant variation in risk presentation and complexity between high and low secure clients, it cannot be assumed that management practices, or staff approach to self-harm is finitely comparable across these contexts.

Of the staff completing the Delphi consultation, the highest percentage were clinical psychologists, a proportion which does not reflect the staff working most directly with SAFS clients, and hence views and experiences reported may be impacted upon by having a less direct working relationship with clients who self-harm.

Inclusion of service user perspectives in the Delphi consultation was an interesting element, however due to levels of disruption on the ward at the time of the focus group, fewer clients were able to contribute their views than originally intended, and hence statements in the Delphi reflecting service user feedback were based on only three individual views from a low secure ward.

Given the iterative process of the Delphi, it is recognised as difficult to retain participants across the study, as this study showed some degree of recruitment atrophy across iterations. Although useful for providing anonymous feedback, the Delphi method is critiqued as a method which only captures consensus across the panellists involved, and are difficult to replicate within other populations.

Acknowledgement that management practices across levels of security will significantly vary needs to be maintained, and hence consensus might have been reached in some areas because of the higher degree of panellists reflecting views and practices in their medium secure wards, than only the two panellists from high secure wards.

Future Research

Larger scale research is needed to expand upon the findings of the above study. Of particular interest may be exploration of whether the way in which staff understand self-harm directly relates to the approaches of care provided by that individual. Given that there are differences in the required levels of security and restrictions between units, further analysis of management of self-harm which comments explicitly on efficacy of the outcome for the client is important.

Given the strong consensus for the helpfulness of relational approaches to managing self-harm, outcome studies investigating the impact of regular and consistent staff support or supervision for managing self-harm on fostering positive attitudes towards clients may be of interest, and whether staff confidence in using relational approaches over physical measures can be fostered.

Further exploration between the views of staff versus service users as how to best manage self-harm is also likely to provide useful insight into the area, and may provide evidence that practices perhaps considered ‘typical’ in forensic care are experienced as detrimental to longer term self-harm management. Indeed, dissemination of the above Delphi to service users is likely to produce an interesting comparison between the two groups, highlighting areas of difference in consensus, as well as adding to a growing evidence base which acknowledges and harnesses the voices of service users, and aims to create more informed approaches to care management.

Conclusion

Findings from this study supported work from previous literature exploring the management of self-harm in forensic services, however unlike other studies, this method reflected practices across numerous units and levels of security. As in Gallagher and Sheldon (2010), physical management responses to self-harm were identified as most frequently employed by staff. Panellists agreed, however, that certain practices such as physical restraint and use of seclusion areas were unhelpful strategies for managing self-harm in their practice, supported by the work of Birch et al. (2011) and Grocutt (2009) who described such practices as detrimental to the development of the therapeutic relationship between staff and clients in secure forensic wards.

Staff achieved consensus for most statements explaining the reasons for why clients self-harm, and high rates of strong consensus of agreement were reached for statements

reflecting the communicative nature of the act, as a response to distress and trauma, and as ways of managing ‘unmanageable’ feelings. These findings support the work of Gough and Hawkins (2000), who identified similar themes in a staff survey conducted on a secure forensic ward.

Numerous studies have reported on the negative views held by staff towards clients who self-harm (Gough & Hawkins, 2005; Wheatley and Austin-Payne, 2009, Sandy & Shaw, 2012), however the above study showed that panellists disagreed with statements describing self-harm as a means to manipulate staff and gain attention, or to avoid transfer to prison.

NICE (2012) guidelines on managing self-harm advocate psychosocial intervention, however little expansion is provided and the guidelines are considered poorly informed by forensic practice, and hence difficult to apply to the unique environment of secure forensic wards. This study, however, provided insight into which models psychologists chose to use in their work with client who self-harm, and exploration of what elements of these models were particularly helpful. ‘Positive focus of approach’, ‘developing new skills’ and ‘emphasis on relational working’ were all elements of the models which psychologists were most useful particularly for working with client who self-harm.

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SAMANTHA COLE BSc Hons, MSc

MANAGEMENT OF CLIENTS WHO SELF-HARM IN UK SECURE FORENSIC UNITS

Section C
Appendices of Supporting Material

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree
of Doctor of Clinical Psychology

APRIL 2016

Appendix A. Further examples of security levels in medium secure (RCP; 2012).

2.Procedural Security			
		<i>Source</i>	<i>Standards for Better Health</i>
2.1	There are relevant, accessible, authorised, up to date policies (no more than 3 years old) and procedures in place to address the areas of practice identified above	(DH)	
Procedural Security - Care and Treatment			
2.2	There are written admission and discharge procedures	(S)	
2.3	There are written policies and procedures that implement the requirements of the Care Programme Approach (CPA)	(S)	
2.4	There is a procedure regarding obtaining consent from patients	(S)	C13b
Procedural Security - Risk and Safety			
2.5	There is a policy in place on the management of aggression and violence which is compliant with NICE 25	(DH)	C3
2.6	The unit has procedures for the management of bullies and for those who have been bullied	(S)	C14c
2.7	There is a policy in place for the observation and monitoring of patients who are at risk of suicide	(S)	C1b
2.8	The procedure for resuscitation of patients is clearly documented, resuscitation equipment is available and its location is clearly identified	(S)	
2.9	There are policies, procedures and guidance for infection control practice	(S)	C4a
2.10	There is a searching policy in relation to patients, visitors, bedrooms, and off ward areas	(DH)	C20a
2.11	There are contingency plans agreed with the police and emergency services (NICE 25) covering as a minimum: hostage taking, serious disorder, riot, escape	(DH)	C1b

Procedural Security - Risk and Safety cont'd			
		<i>Source</i>	<i>Standards for Better Health</i>
2.12	There is a policy on the control of illicit substances covering (a) treatment of substance misuse; (b) education on the dangers of substance abuse; (c) advice to visitors on the dangers of passing illicit/unauthorised substances; (d) a protocol with police for when drugs are discovered; (e) a policy on "searching with cause" for drugs	(DH)	
2.13	There is a policy for administering drugs at dosages above BNF recommendations	(S)	
2.14	There are clear contingency plans in place which meet NICE Clinical Guideline 25 Systems (including: systems to ensure the management of serious incidents, systems for review (both internal and external to organisation), methods to ensure learning, audit process of actions with time scales following review, and clear lines of responsibility and accountability)	(DH)	C1a
2.15	There is a policy for prompt response to staff alarms	(S)	C1b
2.16	There is a procedure for evacuation in case of fire which is rehearsed at regular intervals	(S)	
2.17	There is a procedure in place to ensure that perimeter fence inspection processes are audited	(S)	C20a
2.18	There is a protocol in place for the risk assessment of patient access to telephones, the internet and cameras	(S)	C7c
2.19	Units have in place appropriate procedures to manage the risks created by the movement of patients within the unit and externally (e.g. for hospital/court visits, visitors and staff) proportionate to the level of risk posed, and the effect of those measures on the rights of patients, staff and visitors, and the patients quality of life.	(S)	C7c; C13a
Procedural Security - Responsibilities and Rights			
2.20	There is a policy in place to ensure issues of equality and diversity are regularly monitored	(S)	C18
2.21	The unit has a written complaints procedure	(S)	C14a
2.22	The unit holds data in compliance with legislation (including the Data Protection Act 1984, MAPPA, Caldicott Principle) to ensure maintenance of confidentiality	(S)	C9; C13c

3. Physical Security			
		<i>Source</i>	<i>Standards for Better Health</i>
3.1	The physical security protects the privacy and dignity of patients, facilitates their care and treatment, prevents the passing in of contraband items and offers a protection to the public such as to make escape/abscond difficult.	(DH)	C20a; C20b
Physical Security – Perimeter			
3.2	There is a defined perimeter	(DH)	
3.3	There is EITHER (a) a 5.2m single weld mesh fence surrounding the whole unit (note: fences below 5.2m are not secure fences but anti-dash fences) OR (b) a combination of a 5.2m single weld mesh fence and buildings including reception creating a secure area OR (c) perimeter security designed into the unit consisting of connected buildings, including reception, creating a secure area	(DH)	C20a
3.4	Where there are separate buildings they are connected and create a secure area	(DH)	C20a
3.5	The perimeter is inspected	(DH)	C20a
3.6	There is planned and recorded daily inspection of the perimeter to detect damage and/or contraband	(DH)	C20a
3.7	There is planned and recorded weekly inspection of the perimeter to detect damage and/or contraband	(DH)	C20a
3.8	There are longer planned periods between inspections of the perimeter	(DH)	C20a
Physical Security - Access and Egress			
3.9	Access and egress is via reception	(DH)	C20a
3.10	Access/egress to the secure unit is granted via an airlock controlled from reception	(DH)	C20a
3.11	Access/egress to the secure unit is granted by a single door controlled from reception	(DH)	C20a
3.12	Entry is controlled from reception	(DH)	C20a

Appendix B

CASP (Critical Appraisal Skills Programme)10 Questions to help you make sense of Qualitative Research

1. Was there a clear statement of the aims of the research?

HINT: Consider What was the goal of the research? Why it was thought important? Its relevance?

2. Is a qualitative methodology appropriate?

HINT: Consider If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants Is qualitative research the right methodology for addressing the research goal?

3. Was the research design appropriate to address the aims of the research?

HINT: Consider If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research? HINT: Consider If the researcher has explained how the participants were selected. If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study? If there are any discussions around recruitment (e.g. why some people chose not to take part)?

5. Was the data collected in a way that addressed the research issue?

HINT: Consider If the setting for data collection was justified. If it is clear how data were collected (e.g. focus group, semi-structured interview etc.) If the researcher has justified the methods chosen. If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)? If methods were modified during the study. If so, has the researcher explained how and why? If the form of data is clear (e.g. tape recordings, video material, notes etc) If the researcher has discussed saturation of data.

6. Has the relationship between researcher and participants been adequately considered?

HINT: Consider If the researcher critically examined their own role? Potential bias and influence during (a) Formulation of the research questions (b) Data collection, including sample recruitment and choice of location How the researcher responded to events during the study and whether they considered the implications of any changes in the research design.

7. Have ethical issues been taken into consideration?

HINT: Consider If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained. If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) If approval has been sought from the ethics committee?

8. Was the data analysis sufficiently rigorous?

HINT: Consider If there is an in-depth description of the analysis process? If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data? Whether the researcher explains how the data presented were selected from the original

sample to demonstrate the analysis process. If sufficient data are presented to support the findings? To what extent contradictory data are taken into account? Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation?

9. Is there a clear statement of findings?

HINT: Consider If the findings are explicit? If there is adequate discussion of the evidence both for and against the researchers arguments If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) If the findings are discussed in relation to the original research question?

Appendix C. NHS favourable ethical
approval

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Appendix D. Local R&D Approval

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Appendix E. Focus Group Participant Information Sheet**Participant Information Sheet****Management of Service Users who have Experienced Self Harm in Secure Hospitals****Who is Samantha Cole?**

My name is Sam and I am currently studying to be a psychologist at Canterbury Christ Church university. As part of my study I am doing some research into how forensic wards work with people who have experiences of self-harm.

What's it all about?

I am researching what staff who work in secure services think is the most helpful way to manage and understand service users who self harm whilst on secure wards. I will be asking health professionals a series of questions about how they think clients who self-harm should be cared for and worked with. Before I ask these questions, I want to ask service users what your experiences are- so that the questions I later ask can be shaped by what you think and have experienced regarding how your self-harm is worked with on the ward.

Why are you asking me to join in?

Laura Pipon-Young is supervising this project (the ward psychologist) and has identified that you may have some views or ideas about how staff look after people who self harm. I hope to find out what your experiences of this are, so your views can be carried through into the questions I will later ask staff.

Do I have to take part?

It's up to you whether you join the study. You can read this information sheet which describes the study and if you agree to join in you will be asked to sign a consent form. Whether you join or not will have no effect on the care you receive on the ward.

What does it involve?

I am looking for women and men from across the wards to join a focus group to discuss your experiences of how you feel your self-harm is understood and managed on the ward. This group will be held in the X and will last around an hour. I am hoping to have between 6 and 8 people in the group, which will be run by myself and Laura Pipon-Young. I have some questions to ask, and I am keen for people to expand on these if they feel comfortable. The group will be recorded. I will then type up this recording and look for which ideas and views have come up from the group, and include these topics in the questions I will later ask staff. When the group is over, your participation in the study will end.

What are the up and down sides to joining in?

We understand that talking about experiences of self-harm might be hard, and we will make sure to discuss this in an open, caring and non-judgemental way. For some people, hearing

about others' experiences can feel useful and can feel quite supportive. The group will also give you an opportunity to voice your experiences of what you think helps and doesn't help when you are struggling with self-harm. I understand that how people manage their self harm, and how they are cared for in mental health services is very important, and this study hopes to identify what both staff and service users understand about how best to think about this difficult area.

What if I change my mind?

You can change your mind at anytime, and if you wish to leave the group, you are able to. Due to the group being recorded however, any comments you may have made will be included in the project.

What information about me will you collect?

I will not collect any personal information from you, and if any names come up in the group I will remove these when I type up the recording. Your name will appear on the consent form if you decide to participate, however these will be held securely in a locked cabinet. No personal information will be included about you when the research is written up. The recording of the group, and the notes I make from it will be securely held on a password protected and encrypted USB stick

What will happen if I am interested in participating?

If you wish to participate, I will come along to meet with you and explain a bit more about the study. I will also ask you to sign a consent form, stating that you are happy to be in the group discussion. I can also answer any questions you have. We will then organise a time for the focus group, and we will ask that you come along and join in the discussion.

Will My Care Team Need to Know About This?

If you want to participate, we will need to [REDACTED] they are your Responsible Clinician.

OK, I want to join in, what should I do?

Let Laura or your care team know, and I can come along to see you. It's just a quick meeting to talk about the group and answer any questions you have.

Will my taking part in the study be kept confidential?

We will let your primary nurse or Responsible Clinician know that you are participating in the focus group, otherwise because no further personal details of your will be collected, no one else will know unless you chose to tell them, aside from the other members of the group.

What will happen to the results of the research?

When the study is completed, this will be written up and submitted to Canterbury Christ Church University as part fulfilment on the Clinical Psychology doctoral programme. It is also planned that the paper will be submitted to a journal for publication.

Who has reviewed this study?

This study has been reviewed initially by the Salomons Centre for Applied Psychology, and also by a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion [REDACTED] Research Ethics Committee.

Further Contact Details

If you have any questions, please contact [REDACTED]

If you wish to make a complaint about the study, please contact the Research Director at Salomons Centre for Applied Psychology: Professor Paul Camic

Salomons Centre for Applied Psychology
Runcie Court
David Salomons House
Broomhill Lane
Tunbridge Wells
TN3 0TF

Appendix F. Focus Group Consent Form



Salomons Centre for Applied Psychology

Consent Form

Management of Self Harm on Forensic Inpatient Wards – Focus Group
Samantha Cole

Please initial box

1. I confirm that I have read and understood the participant information sheet dated 25.01.2016 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any point during the focus group, without my medical care or legal rights being affected. ☐
3. I understand that no personal details will be collected about me, and that any comments made by myself which may identify myself or a member of staff will be removed from the write up of the project. ☐
4. I agree to have the group recorded on a digital voice recorder and for transcribed data be securely stored on University and Sussex Partnership Trust computers for 5 years. ☐
5. I agree for my Psychiatrist and my care team to be told about my participation in the group. ☐
6. I understand that should the group facilitators feel that there is a risk of harm to myself or to another person based on what I have discussed in the group, then this will be discussed with my care team outside of the group and will therefore not remain confidential.

MANAGEMENT OF SELF-HARM IN UK FORENSIC WARDS

☐

6. I agree to take part in the above study.

☐

Name of Service User _____

Date _____

Signature _____

Name of Person Taking Consent _____

Date _____

Signature _____

NB. One copy to be provided to service user upon completion.

Appendix G. Email inviting staff to participate in Delphi

Dear Staff Team,

My name is Sam, and I am a trainee Clinical Psychologist currently doing research into the how self harm is managed by staff on forensic inpatient units, which is supervised by Laura Pison-Young. I recently conducted a focus group on hazel ward, and themes from this are being fed into some online surveys for staff to complete. There are 3 online surveys in total, over the next few weeks, the first of which is attached below, and takes around 20-30 minutes to complete. I would be so grateful if you could find the time to have a look and complete the survey and it's for staff from all disciplines (I'm really keen to hear from nursing staff, OT and Support Workers).

<https://www.surveymonkey.co.uk/r/managingselfharm>

Management of Self Harm: Round One Survey

www.surveymonkey.co.uk

Web survey powered by SurveyMonkey.com. Create your own online survey now with SurveyMonkey's expert certified FREE templates.

I understand how valuable your time is, and I very much appreciate your help in this important area of research.

Best wishes

Sam

Samantha Cole
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Appendix H. Focus Group Questions



Salomons Centre for Applied Psychology

Focus Group Questions

These example questions are semi structured and open ended.

- 1) Can people tell me about some of their most positive experiences of being cared for on the ward by staff?
 - i. How about when you had self-harmed?
 - ii. Why was this helpful?

- 2) What do you think helps at times when you've been struggling with feelings of wanting to hurt yourself?
 - i. What do staff do that helps at this time?
 - ii. What do staff do that doesn't help?

- 3) What do you think staff understand about self-harm?
 - i. What would help them understand better?
 - ii. What do you think they 'don't get'?

4. What do you do for yourself that helps you to manage the urge to hurt yourself?
 - i. Could staff help with this?
 - ii. Do you think staff are aware of what you try to do to keep yourself safe?

5. Are there things you know that definitely don't help?
 - i. How about things like having time in seclusion?
 - ii. Having things taken out of your bedroom?

- iii. Temporarily moving into another bedroom?
- iv. Having a member of staff observing you?

6. How do you think your self-harm should be talked about at ward rounds and by the staff in general?

- i. Do you want it talked about? Is this helpful?
- ii. Would you rather it be discussed 1:1?
- iii. Do you feel that you get enough opportunities to talk about it?

7. What other things that happen on the ward help you when you're feeling stressed or struggling with difficult feelings?

- i. Friends, staff, activities, time alone, groups etc.

8. If you could tell all staff on all the wards one thing about how to care for someone who is struggling with self harm, what would it be?

9. If you could tell all staff on all the wards one thing to not do for someone who is struggling with self harm, what would it be?

Appendix I. Sample of Focus Group Transcription

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Appendix J. Example of Coding for thematic analysis of focus group

10/03/2016 15:47

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
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Nodes\\Direct Intervention\\Intervention, Observations

Document

Internals\\transcription2

No	0.0247	2	1	SL	10/03/2016 13:08
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F1 Ok, oh that's when there's like, nothing in there and it's just the bed. Ok. And you kinda mentioned this before, but have, what are obs like, at times, when you, when you are struggling. So if you're on one to one obs. Good? Bad?

K Haven't been on them since ive been here.

F1 How about in the past? Do you like it?

K No. Now and again it helps when I was really struggling.

F1 What is it that helps about it?

K I understand there's someone there for you

F1 Yeah

K But I don't like it. [laughter]

2	SL	10/03/2016 13:08
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F1 Ok, whats the difference, when is it good and when is it less helpful?
 T Ummm... good if you need someone...or for, reassurance, but bad if you either want to do stuff in your private time, or... if you wanna self harm its not great either.
 F1 And I guess there are times when that is what you, you feel like you wanna do, as well
 T Yeah

Nodes\\Direct Intervention\\Intervention, Out of Bedroom

Document

Internals\\transcription2

No	0.0601	2			
			1	SL	10/03/2016 12:29

F1 What do you think help? At difficult times? It might not necessarily be, you know, kind of self harm times, but when you're struggling, what do you reckon staff do that, that, can feel helpful?
 K Umm.. I usually try and do it myself...

F1 Ok. What would that be? What do you do?
 K Stay out of my room
 F1 Stay out of your room? Ok
 K Ride through it. Get thoughts every day of self harming, but I don't do it
 F1 Yeah.
 K ...and they'll probably never go, but its just that control...

Reports\\Coding Summary By Node Report

Page 4 of 15

10/03/2016 15:47

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
			2		SL	10/03/2016 12:33
F1	That's ok. I mean the other side of this I guess, ummm, is that sometimes, staff can get things wrong, ummm, and ummm, sometimes miss bits for us, and I think it's also kind of useful to have think about times when... it hasn't felt as helpful or when staff haven't been able to help as much. Has anybody, had any experiences of it being less, less sort of well, managed, or you've felt less understood... or...					
S	Umm, there was one time when I was really struggling with self harm, when I did it, errr, I self-harmed quite a few times during the day, and I just got locked out of my room and plonked into the chair and I had no support afterwards, after I self harmed					
F1	Ok					
S	I found that quite difficult...					
F1	Yeah...					
S	I felt quite rejected					
F1	Yeah					
S	... felt like they didn't care					
F1	Ok. So if if it's... what would have been your ideal in that situation? So that's what happened, what could have been, how do you think it should have been?					
S	Dunno... I think they should have been quite supportive, and not judged how I was feeling, or when I was self harming they shouldn't have judged me for it					
F1	So it felt at that time that you were being judged?					
S	Yeah					
F1	Ok					
S	And I felt really dis... I felt that they disrespected me, in that sense					
F1	Yeah. So how, if you could wave a magic wand, and make that situation better... would you still have been ok with coming out of your					

room, or would you have wanted to stay in your room.... What's what's...

S Stay in my room

F1 ... and then dress it in my room instead of me coming out, and just take the object off me, that I was using

Nodes\\Direct Intervention\\Intervention, Removing SH Item

Document

Internals\\transcription2

No

0.0203

2

1

SL

10/03/2016 13:05

F2 Can just, if, if, if... that means you can stay in your room, is that something you would view as positive or...
T Yeah. Cause that's what they did last night.
F1 So, took something out of your room, and then you could stay in your room? That worked for you? That was good?
T It's either that or sitting in a room with absolutely nothing but a bed.

2

SL

10/03/2016 13:07

F2 And if it was seclusion, cause obviously at the moment, de-escalation is not available, but would, if you could scale it... where would you say is... the worst alternative to you bedroom. Which is worse? An empty room? De-escalation? Or having your room made safe?
T My room made safe
K Mmm
F2 That's the Worst or the best?
T The best
K Yeah

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
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Nodes\\Direct Intervention\\Intervention, Removing SH Item\\Intervention, Safe Room

Document

Internals\\transcription2

No	0.0130	2			
			1	SL	10/03/2016 13:06

F1 So, took something out of your room, and then you could stay in your room? That worked for you? That was good?
T It's either that or sitting in a room with absolutely nothing but a bed.
F1 Has that, have you ever had that, have you ever had to go in that, in that room?
T Nods
F1 Ok. So that's not good for you. Ok.

			2	SL	10/03/2016 13:07
F2	And what's the worst? Safe room or de-escalation?				
T	Safe room				
F2	That's worse than de-escalation?				
K	Yeah				
F2	Ok.				

Nodes\\Direct Intervention\\Intervention, Removing SH Item\\Intervention, Seclusion**Document****Internals\\transcription2**

No

0.0748

4

1

SL

10/03/2016 12:57

F1 Yeah...How about on the other ward then, when that happened? With the hood up, the pace...
K Ummm... Well, I'd end up getting restrained and just go to seclusion and stuff so...
F1 OK, and was that mainly, was that for kind of if you were feeling more kind of worked up then self harming?
K Yeah
F1 Yeah. What are people's experiences of seclusion then? How is that... Look at that, three head shakes all at the same time!
S Not nice.
F1 Is seclusion used at times when you've self harmed?
S It has been with me a couple of times.
F1 Yeah?
K In a way, I, not prefer it, but when I was assaulting and that, I preferred it then because I'm on my own...There's no one else there for me to hurt. I can reflect on what I've done, when I've calmed down and stuff...
F1 Yeah. So, that time and that space for you, seems like that's quite an important thing
K Yeah but not bloody like six days
F1 Is that how long you were in for?
K At [ward name] yeah once I was there for six days...

Reports\\Coding Summary By Node Report

Page 6 of 15

10/03/2016 15:47

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
			2		SL	10/03/2016 12:57
F2	And sorry, for the ladies on this ward, for clarification, seclusion isn't used for self harm. De escalation might be used					
S	Oh yeah, de-es					
F1	Oh ok, what's, what's de-escalation like then? What would that look like? Because you were shaking, you were kind of shaking your head, is that something that you, that you, have you been used de-escalation?					
T	Mmmm					
F1	Good? Bad? What you think?					
T	Mmmm... depends...					
F1	Ok, what's the difference between it feeling helpful or less helpful do you think?					
T	Depending on whether I want to be on my own or not...					
F1	Ok, and does that, are you... would you be asked about de-escalation... would you, umm, would someone suggest it; "would it be helpful". Or would it something that's kind of...					
T	Sometimes...					
			3		SL	10/03/2016 12:58

F1 Have you used de-escalation or something like that?
 S Yeah, quite a few times, for self harm
 F1 Ok, ok. What's your experience of it?
 S I find it helpful, cause of like what [group member] or [group member] was saying, that it's quite helpful to be on your own, when you're struggling, and not be held in a restraint as well.

4

SL

10/03/2016 13:04

F1 So I wanted to ask about the things, in your experience, ummm, definitely don't help. [inaudible]. So I had some ideas about some things that happen on some wards, when people have self harmed... And you kind of covered this, cause I was wondering about, it's kind of different things that happen. So having time in seclusion... good for you maybe if you like a bit of space, would you agree, if that was...
 T Shakes head
 F1 No? Not in seclusion?
 K In seclusion, yeah
 F1 But for short periods of time?
 K Mmm

Nodes\\Direct Intervention\\Intervention, Restraint

Document

Internals\\transcription2

No	0.0404	4
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1 SL 10/03/2016 12:58

F1 Have you used de-escalation or something like that?

S Yeah, quite a few times, for self harm

F1 Ok, ok. What's your experience of it?

S I find it helpful, cause of like what [group member] or [group member] was saying, that it's quite helpful to be on your own, when you're struggling, and not be held in a restraint as well.

F1 Ok..

S ..held there, its quite supportive...

2 SL 10/03/2016 12:59

K No I don't like being held

F1 Yeah, I noticed both of you two saying no...

K Makes it worse for me, because you need that space. Can't stand two people sitting next to you holding your arms.

10/03/2016 15:47

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
			3	SL		10/03/2016 12:59
S						Cause I find it quite comforting that there's two people sitting with me trying to calm me down as well, so I find it quite comforting.

4 SL 10/03/2016 13:02

F2 Ok. Do you think it's about having that, that honest conversation with people?

K Yeah, 'cause I know, like if I tell them to get off, and then I start walking and then I do it again, they're just gonna chuck me to the floor... they'll hold me even more... So at the end of the day, they're gonna hold you no matter what you do, whether you fight or not, they're gonna hold onto you. It's just the severity. Like if you walk with them, they'll just hold you by your arms, if you don't they'll chuck you to the floor and press their alarms.

F1 So like, in that, in that example you just gave... were staff able to "ok, alright"?

K Yeah

F1 So they listened to you?

K Yeah

Nodes\\Primary Nurses

Document

Internals\\transcription2

No 0.0099 1

1 SL 10/03/2016 12:53

F2 And what about your named nurses?

K What primary nurses?

F2 Your primary nurses? One to ones with primary nurses?

S Mine are very often, errr, hit and miss

F2 Ok, well that's not OK. I hear what you're saying.

K It's hard for me because [named nurse] is the charge nurse. It's hard to get hold of her

S ... is a charge nurse as well

Nodes\\Staff Responses\\Judgement of Staff

Document

Internals\\transcription2

No 0.0129 2

1 SL 10/03/2016 12:46

S Yeah, 'cause I've actually been told by a member of staff that I'm copying other people's behaviours, and I thought that was quite unprofessional of them to say that, very unprofessional

F2 Absolutely

S And they turn round and went, you're just copying someone else behaviour and it's all behavioural and there's nothing really wrong with you. That's what got me

10/03/2016 15:47

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
			2		SL	10/03/2016 12:46

S Yeah
 F1 So that's
 T [inaudible]
 F2 What's that?
 T I've had similar

Nodes\\Staff Responses\\Non Judgemental Staff Approach

Document

Internals\\transcription2

No	0.0082	1			
			1	SL	10/03/2016 12:25

F1 OK, ok, so it was quite, quite soon after it had happened? Ok. What would, what was, what was useful, do you think, about it. What were they asking you?
 S They were just being quite caring and understanding, and they weren't judging me for it.
 F1 Yeah... so not judging?
 S Yeah

Nodes\\Staff Responses\\Staff Empathy

Document

Internals\\transcription2

No	0.0117	1
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1	SL	10/03/2016 12:42
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S Yeah talk to them and explain to them how you're feeling, and then they might be able to put themselves in our kind of shoes, and reflect on how we see it, I don't know how to word it, am I wording it alright?

F2 Mmm

F1 Yeah yeah yeah

S How they would see it through our eyes

F1 Ok,

S ...type of thing...

F1 Ok, so, getting them to really see it through...

S ...yeah...

F1 ...through your eyes. Ok.

Aggregate	Classification	Coverage	Number Of Coding References	Reference Number	Coded By Initials	Modified On
Nodes\\Staff Responses\\Talking with staff						
Document						
Internals\\transcription2						
No		0.1134	9			
				1	SL	10/03/2016 15:24
F1	That's really important. Ok. And was that, can I ask, was that with a member of staff that you knew, kinda quite well, or was it, was it with someone who was just kind of, on shift at the time?					
S	It was with somebody that was on shift at the time					
F1	OK, ok. So it felt nice that someone was there. Ok. How, what do other people think... Do you like to... you're shaking your head there... Do you prefer a bit of space?					
				2	SL	10/03/2016 12:47
F1	How then do we, how do we, stop that happening, do you think? What, 'cause this is about helping people understand your experiences better, and you were saying talking about it is really valuable... DO you feel like you get enough chance to kind of talk about your self harm experiences? Do you get enough opportunity to say "this is what goes on for me, I feel like this sometimes"?					
S	No..					
				3	SL	10/03/2016 12:48
S	Like I said, if I self harm, I just get put in a corner and not spoken to, It's like self harmed today, and the member of staff said they'd come and sit with me for a little while, she didn't bother she just walked straight off. So I haven't had a chance to talk to anyone about, that.					
F1	Ok,. That's hard, that's hard. Yeah.					
S	I find that quite difficult.					

4 SL 10/03/2016 12:48

F1 I don't know, have you ever, like, sat down and really talked about it, to help, do you think people have given you that opportunity?
Have the ward staff kind of...

K Yeah, I just kind of, I do it on my own

5 SL 10/03/2016 12:49

S Yeah I ask for one to ones and they don't happen, they hardly happen. And even if I pester for one to one it still doesn't happen

F2 Well that concerns me, that that's the case

K You don't get really, you don't really get one to ones that's why I never ask in the ward meeting

S 'cause you don't get a one to one, You can put your hand up for one to one and you'll be lucky to get a one to one, if you're lucky

T I get someone allocated to my obs and I don't get one to one

6 SL 10/03/2016 12:52

F1 Do you choose who you have one to one with or...is it... who's about?

S Who's around... who's allocated usually does the one to one...

K Who's about... I just ask anyone. If I need to chat I need to chat, you know what I mean? It doesn't matter who it is

S [inaudible]... they say if they're allocated first, and if they're busy, then you speak to somebody else

K [inaudible]... I'll talk to anyone, if I need to talk someone it's cause I need to talk to someone [inaudible] I prefer that person so I'll talk to them

F1 Ok, so for you it's not... you don't feel so much that it has to be with a certain person...

K I'd prefer it to be, but if I need to talk and they're busy then I'll...

7 SL 10/03/2016 12:53

F1 So it, there are times... it sounds like its difficult to sometimes have those conversations if, if the time isn't always available, and you're saying quite often it feels like, you don't have that one to one time

K Yeah. But I will say, my primary nurse, the other day, did say to me "we haven't had a chat for a while, we'll chat, we'll have a catch up". And in that sense, yeah, she does. And she doesn't one a day to day basis, if I have a struggle then I have to talk to someone and they're busy all the time.

Appendix K: Question 1 Round 1 responses

Management of Self Harm: Round One

SurveyMonkey

Q8 What is your understanding of why some clients on forensic inpatient wards might harm themselves?

Answered: 23 Skipped: 12

#	Responses	Date
1	Because they are distressed	3/17/2016 1:12 AM
2	way of expressing internal emotional distress.	3/16/2016 5:10 PM
3	Managing difficult emotions. Communication of distress. Attempts to gain a sense of control or a sense of connection. Suicide attempts.	3/16/2016 4:02 PM
4	It differs with each person but my experience is that they have reported to me that: this physical harm alleviates the emotional feelings, it can be a way to access general hospital environment and staff which I have observed has a immediate positive effect on improving their mood.	3/16/2016 1:38 PM
5	Most of self-harm that I have personally observed and/or had to deal with was in response to high level of distress although the meaning of self-harm differed from person to person and depended on the context. I guess a few broad categories of reasons for self-harm could be identified but the boundaries between them I think are fluid and one episode of self-harm could have different meaning for different people or when reflected upon at a different time. 1. Instrumental self-harm - to re-enact abuse, to hurt others, to get explicit care, to be held in mind. 2. Self-harm that replaces verbal communication - it makes other people see that the person is in pain but the person can't express themselves. 3. Self-harm with an aim to commit suicide which would be seen as an irrational way out of current problematic life to a better life with death absent from the equation. 4. Self-harm with an aim to die. 5. Self-harm due to confusion and perplexity of a psychotic state when common things around don't make any sense anymore. 6. Self-harm within a sado-masochistic paradigm of relationships with other people around - gratification from other people's helplessness and the self-harming person staying in control of the relationship. 7. Self-harm and mutilation of own body as a protection from becoming an object of sexual desire or a way to deflect development of own sexuality, often in response to sexual and physical abuse and boundaries' transgression in early childhood. Also dealing with body dysmorphia and gender identity issues. 8. Self-harm as a way of dealing with disconnection and detachment.	3/16/2016 12:27 PM
6	for some patients I understand it is part of their illness and an addiction to causing pain to themselves, I also find it appears to be a tool for manipulating situations and staff, and for others again forming part of their illness in relation to the attention they gain and treatment they receive	3/16/2016 11:23 AM
7	For several reasons, potentially suicidal intent, however predominantly as a coping method for managing feelings.	3/16/2016 11:07 AM
8	I understand that clients may feel unable to manage or express their emotions in a way that others would feel was constructive. I also understand that self harming can enable a temporary physical relief to troubling thoughts.	3/16/2016 10:34 AM
9	Often is it a response to internal distress, a means of taking control of strong emotions. At times it is a means of self-soothing and at times a habitual response to distress.	3/16/2016 10:03 AM
10	Manage insufferable emotional distress related to severe attachment disorder by 1. Distracting from it, 2. Eliciting a care response in others 3. Realising it in physiological terms	3/15/2016 11:47 PM
11	The majority of patients I have worked with who self harm have a diagnosis of borderline personality disorder. In my experience these individuals use self harm as a way to communicate/alleviate distress. Most have a low sense of worth and low self esteem. My opinion is that another function of self harming is to receive attention, learned experiences have positively reinforced that self harming results in staff spending increased amounts of time with the individuals. Self harming usually via cutting or ligature tying but also use other methods such as medications abuse, substance misuse, restriction of food/fluid intake.	3/15/2016 10:30 PM
12	Many patients have experienced traumatic early life experiences and in the absence of nurturance and healthy role models they have often developed maladaptive coping responses including violence (directed towards the self and others) to manage emotional distress. Many patients also report that physical pain is more bearable than emotional pain and DSH provides a form of relief/taking away their emotional pain. Also can be a form of self-punishment and attack on the self, particularly for patients who have been abused and have very punitive internal model.	3/15/2016 5:20 PM

Management of Self Harm: Round One

SurveyMonkey

13	Presence of severe enduring mental illness. Poor impulse control. Verbal skills relatively weaker than performance skills, leading to poor thinking-through. Anger with staff, family etc. turned in on themselves. Use of illicit substances within the secure setting. Attempt to stay in hospital rather than return to prison (for transferred prisoners). Attempt to stay in hospital rather than be discharged into a hostile community (for non-prisoners). "Copycat" phenomenon if other patients self-harming. Life-events leading to despair-long sentence, new charges, "Dear John" letters, bereavement. Anniversary of index offence or other significant event.	3/15/2016 4:21 PM
14	method of communication self assault - embodied self hatred, or self punishment (internalised malevolent other) overwhelmed, / feeling unable to carry on passive aggressive attack on caregivers psychotic misconceptions OCD schema's boredom - needing to feel something transferring emotional wounds into physical domain (trauma) identity - the significance of wearing scars	3/15/2016 3:56 PM
15	As a response to otherwise intolerable distress	3/15/2016 2:44 PM
16	Multiple reasons: some more endogenous such as gaining a sense of relief from emotional pain or expressing feelings, possibly as part of 'faulty' coping skills and emotionally unstable personality traits. Other reasons can be more situational such as gaining staff attention (either emotional concern or direct physical care in terms of dressing the wound), getting a ward move, expressing anger towards staff and peers. In some cases, it can be a form of protest at being incarcerated or specific grievances. Getting a move to an outside physical care hospital is sometimes the goal.	3/15/2016 10:21 AM
17	Many reasons: distress; frustration; intense feelings; for release of tension/pent up emotion	3/14/2016 7:03 PM
18	History of complex trauma, invalidating environments and repeat of this through their lives in different contexts, ongoing interpersonal and intrapersonal dilemmas, limited coping skills that are more effective, reinforcement of behaviour itself (eg increased care and support that could be limited in inpatient setting), diagnosed mental health difficulty (eg mood disorders, psychosis), learning from environments	3/11/2016 10:20 PM
19	Patients experience what feels to them to be intolerable emotional states / intolerable recurrent thoughts and in the absence of other strategies to reduce their distress they harm themselves (and hence achieve a 'break' from suffering). Sometimes their actions communicate to others that they are distressed and need help. I think there are a multitude of reasons, these are just a few. Once someone has used self harm for awhile, I also believe it has an addictive quality, and becomes difficult to break the habit.	3/11/2016 6:28 PM
20	It may be because they are experiencing feeling that they find intolerable or overwhelming. Self harm could feel like a release for anger or sadness for example. It could be that they feel nothingness and numbness and wish to feel something. It could partially be reinforced as a way of drawing in care and a nurturing response. It could be a form of self punishment.	3/11/2016 6:22 PM
21	Difficulties in managing emotion - possibly due to traumatic histories Sensory - particularly in LD settings As a means of communicating distress	3/11/2016 5:44 PM
22	To communicate distress To replace emotional pain with physical pain which is more tolerable As a suicide attempt resulting from feelings of helplessness and hopelessness	3/11/2016 4:37 PM
23	For some it is a coping strategy, a way of managing unmanageable feelings brought about by trauma. It is a panacea, natural heroin, a painkiller from the emotional and unreliable pain they suffer. Some people use it as a way to punish themselves, as they are familiar with, and need to act on the feeling they deserve to be hurt. For some it has become the only way they can cope as incarceration limits other method tried and tested ie drugs, drink, sex... in an environment which seems to strive to control to limit harm it can be a small victory of their control to be able to self harm. It can be a badge of identity, of being a survivor, of being part of a community. Some people are reacting to their voices and feel powerless to not harm themselves. Some people carry out self harm in reaction to deep body loathing/low self esteem.	3/11/2016 3:58 PM

Appendix L. Examples of Question One Thematic Coding

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Appendix M. Rounds 1-3 of Delphi survey



Management of Self Harm: Round One

The Management of Self Harm on Forensic Inpatient Units: A Delphi Method

Thank you for showing your interest in participating in this research project.

This research is conducted by Samantha Cole, Trainee Clinical Psychologist for completion of her DClinPsych Major Research Project carried out through Salomons Centre for Applied Psychology.

To be eligible to participate in this research you need to have had at least one year working directly with clients on forensic inpatient wards, and hence some experience in the care and management of clients who engage in self harming behaviours during their time on the ward. Participants are also welcome who have significant research experience on the management of self harm in forensic inpatient environments. Qualified staff from all disciplines are welcome to participate.

This questionnaire requires completion by 5pm on Friday 18th March 2016.

Please note, this survey is compatible for completion on most smart phones.



Management of Self Harm: Round One

Participant Information Sheet

Who am I and what is the Study for?

My name is Samantha Cole and I am a Trainee Clinical Psychologist at the Salomons Centre for Applied Psychology. This research is for my MRP (major research project) for completion of my doctorate in Clinical Psychology. The study has been approved by IRAS and local R&D ethics review panel.

What is the study about?

I worked for several years as an assistant psychologist on a medium secure forensic ward, and have continued to have a particular interest in how self harm is conceptualised and managed within such services. National guidelines are in place for the management of self-harm, however implementing some recommendations within the restrictions of forensic inpatient wards can be a challenge. This research aims to access the views, experiences and practices of experts (either through clinical or research work in this field) with the aim to draw together what are the experiences of managing clients who self harm, what feels most helpful in working with these clients, and how to understand the self-harm expressed within these services.

What will the study involve?

This research is a Delphi Study, which is a method of data collection which aims to collate the views of 'expert panelists' within a particular field. These panelists will receive a questionnaire by email with a link to the online survey, a total of three times, whereby the answers of all respondents are indicated after the second round, and the panelist is requested to answer again, in the light of collated responses shown.

Given the importance of service user involvement in research, questionnaires for the second round of the Delphi will be in part shaped by the responses of service users having participated in a focus group to share their experiences of care around self-harm in forensic inpatient settings.

What Do I need to Qualify to Participate?

I am asking for a variety of clinicians who have had at least one years experience of working on forensic inpatient wards with clients who have self harmed , in the last 5 years. I am interested in hearing from psychologists, nurses, and psychiatrists and other ward staff. I am also keen to recruit individuals who have written and researched on the management of self-harm in forensic populations.

What are the time requirements?

Once you have consented to participate, you will be able to complete the first of three questionnaires in total, one approximately every two weeks. These questionnaires are completed online, and take around 30-45 minutes. The first round will invite you to answer six questions. The following two rounds will be mainly quantitative responses. Completion of the three rounds of the Delphi questionnaire will end your time requirements for the study.

Who's going to see my data?

No personal information will be collected from you as part of this study, however I will ask your discipline and years experience working in this area of expertise. I will also request your email addresses so you can receive the next round of the Delphi, however these will not be stored in the same place as study data.

How Will I Participate?

If you wish to participate, please click "next" under this text to complete the first round of the Delphi. Over the next 6 weeks, you will receive a survey twice more. On the final round, you will see the responses of other participants when you are requested to make your final response.



Management of Self Harm: Round One

Consent to Participate

By completing the below demographic information, you are consenting to participate in the following research study, as outlined in the Participant Information Sheet

* 1. Please select your primary professional background from the list below

- ☐ Clinical Psychologist
- ☐ Mental Health Nurse
- ☐ Psychiatrist
- ☐ Occupational Therapist
- ☐ General Nurse
- ☐ Forensic Psychologist
- ☐ Psychotherapist
- ☐ Support Worker
- ☐ Other (please specify)

* 2. Please enter your email address for which you wish to receive the next round of the Delphi questionnaire

* 3. Please enter the number of years you have worked on forensic inpatient wards

- ☐ 1-3 years
- ☐ 4-6 years
- ☐ 7 + years
- ☐ My experience is predominantly in research related to this field

4. Please indicate your current Agenda for Change band (if NHS staff)

* 5. I work predominantly with...

- ☐ Males
- ☐ Females
- ☐ Both males and female

* 6. Most of my clinical experience has been on...

- ☐ Low secure wards
- ☐ Medium secure wards
- ☐ High secure wards
- ☐ Other (please specify)

* 7. Please check the boxes below to indicate your consent to participate in the study.

- ☐ I consent to participate in the above outlined research project
- ☐ I understand I will receive a total of three iterations of an online survey
- ☐ I confirm that I meet the criteria outlined above to participate in this research



Management of Self Harm: Round One

* 8. What is your understanding of why some clients on forensic inpatient wards might harm themselves?

* 9. What approaches do you use in your current practice to manage clients who self harm? These might include psychological approaches, security procedures, practical activities etc.?

* 10. In your view, how useful have these approaches been for clients and staff teams?

* 11. What are your views on the use of ward procedures for management of self harm? These may include the use of safe rooms, seclusion, de-escalation suites, physical restraint or direct observation.



12. FOR PSYCHOLOGISTS ONLY: Are there any theoretical models/ approaches which you find particularly helpful in working with clients who self harm?



**Management of Self Harm: Round One****End of Survey**

Thank you so much for completing this first round of the Delphi, your time is very much appreciated. Data from these responses will be analysed, and the next round (the second of three) will be sent to the email address you provided above.

Many thanks

Samantha



Management of Self Harm: Round Two

The Management of Self Harm on Forensic Inpatient Units: A Delphi Method

Thank you for participation in the first round of the Delphi Questionnaire. The data has been analysed and the following survey is informed from this data, along with feedback from service users.

This research is conducted by Samantha Cole, Trainee Clinical Psychologist for completion of her DClinPsych Major Research Project carried out through Salomons Centre for Applied Psychology.

To be eligible to participate in this research you need to have had at least one year working directly with clients on forensic inpatient wards, and hence some experience in the care and management of clients who engage in self harming behaviours during their time on the ward. Participants are also welcome who have significant research experience on the management of self harm in forensic inpatient environments. Qualified staff from all disciplines are welcome to participate.

**This questionnaire requires completion by 5pm on Monday 4th April 2016.
*Please note, this survey is compatible for completion on most smart phones.***



Management of Self Harm: Round Two

Participant Information Sheet

Who am I and what is the Study for?

My name is Samantha Cole and I am a Trainee Clinical Psychologist at the Salomons Centre for Applied Psychology. This research is for my MRP (major research project) for completion of my doctorate in Clinical Psychology. The study has been approved by IRAS and local R&D ethics review panel.

What is the study about?

I worked for several years as an assistant psychologist on a medium secure forensic ward, and have continued to have a particular interest in how self harm is conceptualised and managed within such services. National guidelines are in place for the management of self-harm, however implementing some recommendations within the restrictions of forensic inpatient wards can be a challenge. This research aims to access the views, experiences and practices of experts (either through clinical or research work in this field) with the aim to draw together what are the experiences of managing clients who self harm, what feels most helpful in working with these clients, and how to understand the self-harm expressed within these services.

What will the study involve?

This research is a Delphi Study, which is a method of data collection which aims to collate the views of 'expert panelists' within a particular field. These panelists will receive a questionnaire by email with a link to the online survey, a total of three times, whereby the answers of all respondents are indicated after the second round, and the panelist is requested to answer again, in the light of collated responses shown.

Given the importance of service user involvement in research, questionnaires for the second round of the Delphi will be in part shaped by the responses of service users having participated in a focus group to share their experiences of care around self-harm in forensic inpatient settings.

What Do I need to Qualify to Participate?

I am asking for a variety of clinicians who have had at least one years experience of working on forensic inpatient wards with clients who have self harmed, in the last 5 years. I am interested in hearing from psychologists, nurses, and psychiatrists and other ward staff. I am also keen to recruit individuals who have written and researched on the management of self-harm in forensic populations.

What are the time requirements?



Management of Self Harm: Round Two

Demographic Information

* 1. Please select your primary professional background from the list below

- ☐ Clinical Psychologist
- ☐ Mental Health Nurse
- ☐ Psychiatrist
- ☐ Occupational Therapist
- ☐ General Nurse
- ☐ Forensic Psychologist
- ☐ Psychotherapist
- ☐ Support Worker
- ☐ Other (please specify)

* 2. Please enter your email address for which you received this survey

* 3. Please enter the number of years you have worked on forensic inpatient wards

- ☐ 1-3 years
- ☐ 4-6 years
- ☐ 7 + years
- ☐ My experience is predominantly in research related to this field

4. Please indicate your current Agenda for Change band (if NHS staff)

* 5. I work predominantly with...

- ☐ Males
- ☐ Females
- ☐ Both males and female

* 6. Most of my clinical experience has been on...

- ☐ Low secure wards
- ☐ Medium secure wards
- ☐ High secure wards
- ☐ Other (please specify)



Management of Self Harm: Round Two

Understanding of why Clients Self-Harm

The following questions are shaped from data from the first round of the questionnaire you completed.

Please indicate your level of agreement for the following sentences, based on your over all understanding of why clients in secure forensic inpatient services might self-harm.

* 7. My understanding of why clients in secure forensic services may self-harm Eliciting a Staff Response

	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
Clients self-harm to manipulate staff and gain attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm in the hope of leaving the ward (E.g. move to general hospital ward)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm to avoid transfer to prison	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm to avoid discharge into the community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as a way to communicate to staff their distressing emotions which they struggle to verbalise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:

* 8. My understanding of why clients in secure forensic services may self-harm Meaning of Self-Harm

	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Disagree Strongly
Clients self-harm as a communication of their internal world	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm due to poor coping skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm due to feelings of low self-esteem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm in an attempt to gain some control of their feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as an act of internalised anger, rather than harming others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm due to the intensity of their distressing feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm due to experiences of complex trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as an attack on the relationships developed with staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm in response to a current event (e.g. family difficulties, leave changes etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as a way of managing and controlling their distress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm because they wish to end their life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as a means of 'de-sexualising' their bodies in response to abuse experiences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:



Management of Self Harm: Round Two

* 9. My understanding of why clients in secure forensic services may self-harm Self Management

	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
Clients use the physical pain of self-harm as a means to soothe emotional pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as a means of self-punishment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients use self-harm as a distraction from emotional pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm because they are addicted to the act	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as an attempt to escape feelings of numbness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm due to poor impulse control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as a way to manage distressing thoughts and feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:

* 10. My understanding of why clients in secure forensic services may self-harm. Other Factors

	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
Clients can gain a sense of identity and belonging as a person who self-harms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients can self-harm to copy other ward residents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm as a reaction against their incarceration on the ward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm because they have a diagnosis of Personality Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clients self-harm because they have a severe mental illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:



Management of Self Harm: Round Two

Approaches to Managing Self-Harm

* 11. Of the list below, please indicate how frequently you feel the following approaches to managing self-harm are used in your experiences of secure forensic inpatient wards: Physical Security

	Very Often	Quite Often	Neither Often nor Rarely	Quite Rarely	Very Rarely
Physical restraint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preventing client access to their bedroom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removal of risk item (e.g. an item a client is using to harm themselves with)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Room searches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of de-escalation suite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Restriction of access to ward leave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of safe rooms (e.g. empty bedroom, rather than client accessing own room)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implement/ Increase staff observation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of seclusion area	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:

* 12. Of the list below, please indicate how frequently you feel the following approaches to managing self-harm are used in your experiences of secure forensic inpatient wards: Relational Security

	Very Often	Somewhat Often	Neither Often nor Rarely	Quite Rarely	Very rarely
1:1 time offered by ward staff when client reports/presents as wanting to harm themselves (prior to episode of self-harm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1:1 time offered by ward staff after client has harmed themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Minimal staff interaction is provided during self-harm episode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff team receives on going support and supervision around the management of clients who self-harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1:1 time specifically provided by client's Primary Nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing or encouraging attendance of client reflective groups/ peer support group work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provision of harm-minimisation strategies (e.g.holding ice cubes, 'theatre blood', etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using Positive Risk Management approaches, such as (where appropriate) encouraging client to dress their own wound or remove a loosely tied ligature	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:



Management of Self Harm: Round Two

* 13. Of the list below, please indicate how frequently you feel the following approaches to managing self-harm are used in your experiences of secure forensic inpatient wards: Procedural Security

	Very Often	Somewhat Often	Neither Often nor Rarely	Somewhat Rarely	Very Rarely
Transfer client to general hospital/ accident and emergency department	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Review of client risk assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Review of client care (e.g. consider referrals that may be required such as Autism assessment, anger management work, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Review medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implement contingency plan for client regarding self-harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assess severity of harm caused, and use this to inform level of staff intervention required	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:



Management of Self Harm: Round Two

How Helpful are Interventions for Self-Harm?

The following questions are shaped from data from the first round of the questionnaire you completed.

Please indicate how helpful you consider the following strategies to be based on your over all understanding of why clients in secure forensic inpatient services might self-harm.

* 14. Of the list below, please indicate how helpful you consider the following strategies are in the on going care of a client who self-harms: Physical Security

	Very Helpful	Somewhat Helpful	Neither Helpful nor Unhelpful	Somewhat Unhelpful	Very Unhelpful
Physical restraint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Preventing client access to their bedroom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Removal of risk item (e.g. an item a client is using to harm themselves with)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Room searches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of de-escalation suite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Restriction of access to ward leave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of safe rooms (e.g. empty bedroom, rather than client accessing own room)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implement/ Increase staff observation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use of seclusion area	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:

* 15. Of the list below, please indicate how helpful you consider the following strategies are in the on going care of a client who self-harms: Relational Security

	Very Helpful	Somewhat Helpful	Neither Helpful nor Unhelpful	Somewhat Unhelpful	Very Unhelpful
1:1 time offered by ward staff when client reports/presents as wanting to harm themselves (prior to episode of self-harm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1:1 time offered by ward staff after client has harmed themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Minimal staff interaction is provided during self-harm episode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff team receives on going support and supervision around the management of clients who self-harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1:1 time provided specifically with client's Primary Nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing or encouraging attendance of client reflective groups/ peer support group work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provision of harm-minimisation strategies (e.g.holding ice cubes, 'theatre blood', etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:

* 16. Of the list below, please indicate how helpful you consider the following strategies are in the on going care of a client who self-harms: Procedural Security

	Very Helpful	Somewhat Helpful	Neither Helpful nor Unhelpful	Somewhat Unhelpful	Very Unhelpful
Transfer client to general hospital/ accident and emergency department	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Review of client risk assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Review of client care (e.g. consider referrals that may be required such as Autism assessment, anger management work, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Review medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Implement contingency plan for client regarding self-harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assess severity of harm caused, and use this to inform level of staff intervention required	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:



Management of Self Harm: Round Two

Service User Focus Group

A small focus group was run on a low secure forensic inpatient ward to explore the views of service user's on the care and management they have received for their self-harm.

The most significant themes identified from the group were around preferred physical security intervention in response to an incident of self harm, staff member emotional response, wound management and allocated 1:1 time with staff.

* 17. For the statements below, please indicate how much of a priority you feel the following areas are in your experience of caring for people who self harm.

	High Priority	Somewhat High Priority	Neither High nor Low Priority	Somewhat Low Priority	Low Priority
If possible, managing self harm wounds in client bedroom to avoid other ward residents seeing injuries in communal areas (assuming incident occurred in the client's bedroom)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Listening to the client's explanation and understanding of their self-harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Maintaining a non-judgemental approach to clients who have harmed themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Maintaining an empathetic approach to clients who have harmed themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recognising that clients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ensuring support is offered to clients when they have been removed from their bedrooms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being aware of the individual risk and care plans for clients who self-harm, and the individual reasons for which a client may harm themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Where possible, to make a client's bedroom safe, rather than moving them to a safe room or seclusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Further Comments:



Management of Self Harm: Round Two

* 18. Are you a Clinical or Forensic Psychologist?

☐ Yes

☐ No



Management of Self Harm: Round Two

Psychological Models and Approaches

The following questions are for Psychologists only.

19. Of the models and approaches below that you use, please provide some brief points on why you feel these are useful in your work with clients who self-harm in secure forensic services

Dialectical Behaviour Therapy	
Compassion Focussed Therapy	
Mentalization Based Therapy	
Cognitive Behaviour Therapy	
Acceptance and Commitment Therapy	
Narrative Therapy	
Focus on Therapeutic Relationship	
Mindfulness	
STEPPS	
Schema Therapy	
Psychodynamic Working	
EMDR	
Recovery Focused Work	
Trauma Focused Work	



Management of Self Harm: Round Two

End of Survey

Thank you so much for completing this second round of the Delphi Consultation, your time is very much appreciated.

You will soon receive this survey again for the final time, however responses from other panellists will be included for your consideration.

**Many thanks,
Samantha**



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

The Management of Self Harm on Forensic Inpatient Units: A Delphi Method

Thank you for participation in the first two rounds of the Delphi Questionnaire. This is the last survey you will receive.

PLEASE READ THE FOLLOWING IMPORTANT INFORMATION:

This version of the survey is specifically tailored to your responses from round two. Each statement you are asked to rate is the same as round 2, however you will also see the percentage response rates for all participants in the study in bracketed red text under each scale rating response.

**YOUR response from the previous round will be marked with an X
Ratings from other participants are shown for your consideration, and you may chose to alter your original response, however please feel under no obligation to do so.
This survey will close on Tuesday 19th April and a reminder will be sent prior to this date.**

Example question showing group response rates in red and your previous answer to round two shown with a blue X. You are therefore able to see how other participants have rated this statement, along with your own response. Please rate your response to the statement again, changing if you wish. A selection of anonymous comments is also available for your consideration.

* 8. Meaning of Self-Harm (Continued....)

	Strongly Agree (10%) X	Somewhat Agree (75%)	Neither Agree nor Disagree (15%)	Somewhat Disagree (0%)	Disagree Strongly (0%)
Clients self-harm due to feelings of low self-esteem	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

This round of the Delphi will also include a selection of anonymous comments from the previous round.

Thank you to everybody for your comments, they have been very helpful and insightful, as well as providing a valuable addition to the research area.

The depth of feeling and enthusiasm of comments left on the survey are I think a clear testament to how important people feel this area of care is, and how necessary further research is into this topic.

By way of a reminder, the purpose of the Delphi is to facilitate discussion around the potentially wide variety of views and experiences of staff working in this important area of health care, and I hope to be able to provide all panelists with the chance to voice their individual perspectives freely, whatever these may be.

Therefore, all the statements and language included in the survey are taken directly from participants' feedback in the first round of the survey. Some of these perspectives may reflect your own whereas others may "jar". The purpose is to establish consensus where it exists as well as where there are areas of ongoing disagreements.

Thank you again for taking part and I do hope it has been an interesting process. I am very much looking forward to sharing the results with you all.



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

Understanding of why Clients Self-Harm

The following questions are shaped from data from the first round of the questionnaire you completed.

Percentages in red under each scale show you the responses of all participants of the survey. Your response from round 2 is indicated by a X

* 1. Eliciting a Staff Response (continued...)

	Strongly Agree (10%)	Somewhat Agree (20%)	Neither Agree nor Disagree (25%)	Somewhat Disagree (15%)	Strongly Disagree (30%) X
Clients self-harm in the hope of leaving the ward (e.g. move to general hospital ward)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 2. Eliciting a Staff Response (continued...)

	Strongly Agree (0%)	Somewhat Agree (15%)	Neither Agree nor Disagree (20%)	Somewhat Disagree (35%)	Strongly Disagree (30%) X
Clients self-harm to avoid transfer to prison	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 3. Eliciting a Staff Response (Continued...)

	Strongly Agree (0%)	Somewhat Agree (25%)	Neither Agree nor Disagree (10%)	Somewhat Disagree (45%)	Strongly Disagree (20%) X
Clients self-harm to manipulate staff and gain attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Some comments for your consideration:

"...'manipulate' and 'gain attention' have negative associations which are not useful but we all need some degree of attention from those around us..."

"...I have disagreed with the this statement as the language used is fairly inflammatory, however, I do think that clients may use self harm as a way of trying to have their needs met when they have no other strategies."

* 4. Eliciting a Staff Response (continued...)

	Strongly Agree (60%) X	Somewhat Agree (40%)	Neither Agree nor Disagree (0%)	Somewhat Disagree (0%)	Strongly Disagree (0%)
Clients self-harm as a way to communicate to staff their distressing emotions which they struggle to verbalise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 5. Eliciting a Staff Response (continued...)

	Strongly Agree (5%)	Somewhat Agree (35%)	Neither Agree nor Disagree (30%)	Somewhat Disagree (15%)	Strongly Disagree (15%) X
Clients self-harm to avoid discharge to the community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Comments:



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

* 7. My understanding of why clients in secure forensic services may self-harm Meaning of Self-Harm

	Strongly Agree (60%)	Somewhat Agree (35%) X	Neither Agree nor Disagree (5%)	Somewhat Disagree (0%)	Disagree Strongly (0%)
Clients self-harm as a communication of their internal world	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 8. Meaning of Self-Harm (Continued....)

	Strongly Agree (30%)	Somewhat Agree (60%) X	Neither Agree nor Disagree (5%)	Somewhat Disagree (5%)	Disagree Strongly (0%)
Clients self-harm due to poor coping skills	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"I think this language is a little stigmatising and judgemental, and there might be a better way of explaining it. Like, not having had the opportunity to learn, or capacity at the time to utilise more socially accepted/self nurturing coping skills".

* 9. Meaning of Self-Harm (Continued....)

	Strongly Agree (10%)	Somewhat Agree (75%) X	Neither Agree nor Disagree (15%)	Somewhat Disagree (0%)	Disagree Strongly (0%)
Clients self-harm due to feelings of low self-esteem	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 10. Meaning of Self-Harm (Continued....)

	Strongly Agree (30%)	Somewhat Agree (55%) X	Neither Agree nor Disagree (10%)	Somewhat Disagree (5%)	Disagree Strongly (0%)
Clients self-harm in an attempt to gain some control of their feelings	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 11. Meaning of Self-Harm (Continued....)

	Strongly Agree (15%)	Somewhat Agree (65%) X	Neither Agree nor Disagree (20%)	Somewhat Disagree (0%)	Disagree Strongly (0%)
Clients self-harm as an act of internalised anger, rather than harming others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 12. Meaning of Self-Harm (Continued....)

	Strongly Agree (40%) X	Somewhat Agree (60%)	Neither Agree nor Disagree (0%)	Somewhat Disagree (0%)	Disagree Strongly (0%)
Clients self-harm due to the intensity of their distressing feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 13. Meaning of Self-Harm (Continued....)

	Strongly Agree (50%) X	Somewhat Agree (40%)	Neither Agree nor Disagree (10%)	Somewhat Disagree (0%)	Disagree Strongly (0%)
Clients self-harm due to experiences of complex trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 14. Meaning of Self-Harm (Continued....)

	Strongly Agree (15%)	Somewhat Agree (40%)	Neither Agree nor Disagree (35%)	Somewhat Disagree (5%) X	Disagree Strongly (5%)
Clients self-harm as an attack on the relationships developed with staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 15. Meaning of Self-Harm (Continued....)

	Strongly Agree (20%) X	Somewhat Agree (80%)	Neither Agree nor Disagree (0%)	Somewhat Disagree (0%)	Disagree Strongly (0%)
Clients self-harm in response to a current event (e.g. family difficulties, leave changes etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 16. Meaning of Self-Harm (Continued....)

	Strongly Agree (55%) X	Somewhat Agree (35%)	Neither Agree nor Disagree (5%)	Somewhat Disagree (5%)	Disagree Strongly (0%)
Clients self-harm as a way of managing and controlling their distress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 17. Meaning of Self-Harm (Continued....)

	Strongly Agree (5%)	Somewhat Agree (15%) X	Neither Agree nor Disagree (45%)	Somewhat Disagree (35%)	Disagree Strongly (0%)
Clients self-harm because they wish to end their life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 18. Meaning of Self-Harm (Continued....)

	Strongly Agree (20%)	Somewhat Agree (30%) X	Neither Agree nor Disagree (35%)	Somewhat Disagree (15%)	Disagree Strongly (0%)
Clients self-harm as a means of 'de-sexualising' their bodies in response to abuse experiences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. Comments:



Salomon's Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

* 20. My understanding of why clients in secure forensic services may self-harm Self Management

	Strongly Agree (22%) X	Somewhat Agree (44%)	Neither Agree nor Disagree (33%)	Somewhat Disagree (0%)	Strongly Disagree (0%)
Clients use the physical pain of self-harm as a means to soothe emotional pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 21. Self Management (continued...)

	Strongly Agree (11%)	Somewhat Agree (67%) X	Neither Agree nor Disagree (17%)	Somewhat Disagree (6%)	Strongly Disagree (0%)
Clients self-harm as a means of self-punishment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 22. Self Management (continued...)

	Strongly Agree (39%) X	Somewhat Agree (50%)	Neither Agree nor Disagree (11%)	Somewhat Disagree (0%)	Strongly Disagree (0%)
Clients use self-harm as a distraction from emotional pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 23. Self Management (continued...)

	Strongly Agree (6%)	Somewhat Agree (44%) X	Neither Agree nor Disagree (44%)	Somewhat Disagree (6%)	Strongly Disagree (0%)
Clients self-harm because they are "addicted" to the act	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"I've ticked somewhat agree to them all, but the wording on two jar with me a little, one is that they are 'addicted' - this is usually used in a reductionist way without understanding what the word means. I think a short explanation of the process of the 'addiction' is better".

* 24. Self Management (continued...)

	Strongly Agree (22%)	Somewhat Agree (67%) X	Neither Agree nor Disagree (11%)	Somewhat Disagree (0 %)	Strongly Disagree (0%)
Clients self-harm as an attempt to escape feelings of numbness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 25. Self Management (continued...)

	Strongly Agree (6%)	Somewhat Agree (72%) X	Neither Agree nor Disagree (17%)	Somewhat Disagree (6%)	Strongly Disagree (0%)
Clients self-harm due to poor impulse control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 26. Self Management (continued...)

	Strongly Agree (44%) X	Somewhat Agree (50%)	Neither Agree nor Disagree (6%)	Somewhat Disagree (0%)	Strongly Disagree (0%)
Clients self-harm as a way to manage distressing thoughts and feelings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. Comments:



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

* 28. My understanding of why clients in secure forensic services may self-harm. Other Factors

	Strongly Agree (6%)	Somewhat Agree (39%)	Neither Agree nor Disagree (39%)	Somewhat Disagree (17%) X	Strongly Disagree (0%)
Clients can gain a sense of identity and belonging as a person who self-harms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 29. Other factors (continued...)

	Strongly Agree (0%)	Somewhat Agree (56%) X	Neither Agree nor Disagree (22%)	Somewhat Disagree (17%)	Strongly Disagree (6%)
Clients can self-harm to copy other ward residents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 30. Other factors (continued...)

	Strongly Agree (0%)	Somewhat Agree (33%) X	Neither Agree nor Disagree (44%)	Somewhat Disagree (22%)	Strongly Disagree (6%)
Clients can self-harm as a reaction against their incarceration on the ward	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 31. Other factors (continued...)

	Strongly Agree (6%)	Somewhat Agree (11%)	Neither Agree nor Disagree (22%)	Somewhat Disagree (33%)	Strongly Disagree (28%) X
Clients can self-harm because they have a diagnosis of Personality Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"...Clients who self harm often have a diagnosis of Personality Disorder, that is part of the criteria, it does not explain the behaviour".

"...I tend to stay away from medical terminology/diagnostic categorisation in this area because it tends to do more harm than good with regards treating the person: obviously there may be people who self harm in response to voices; but the voices are often connected to early trauma, so I would be wary of implicating the diagnosis as a causal factor".

* 32. Other factors (continued...)

	Strongly Agree (0%)	Somewhat Agree (17%)	Neither Agree nor Disagree (22%)	Somewhat Disagree (44%)	Strongly Disagree (17%) X
Clients self-harm because they have a severe mental illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

"Not too sure about some of these ones. I don't think mental illness or PD is a 'reason' for self harm. It is a description of someone's symptoms".

33. Comments:



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

How Helpful are Interventions for Self-Harm?

The following questions are shaped from data from the first round of the questionnaire you completed.

Please indicate how helpful you consider the following strategies to be based on your over all understanding of why clients in secure forensic inpatient services might self-harm.

- * 34. Of the list below, please indicate how helpful you consider the following strategies are in the on going care of a client who self-harms: Physical Security

	Very Helpful (0%)	Somewhat Helpful (24%) X	Neither Helpful nor Unhelpful (24%)	Somewhat Unhelpful (35%)	Very Unhelpful (18%)
Physical restraint	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- * 35. Physical Security (continued...)

	Very Helpful (0%)	Somewhat Helpful (24%)	Neither Helpful nor Unhelpful (41%) X	Somewhat Unhelpful (24%)	Very Unhelpful (12%)
Preventing client access to their bedroom	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

- * 36. Physical Security (continued...)

	Very Helpful (18%)	Somewhat Helpful (53%) X	Neither Helpful nor Unhelpful (12%)	Somewhat Unhelpful (18%)	Very Unhelpful (0%)
Removal of risk item (e.g. an item a client is using to harm themselves with)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"People need to be judged as individuals, are they also a threat to others, can they be 'trusted' with their own implements?"

"Sometimes a strategy which is unhelpful in terms of long-term change and therapeutic relationships can be helpful in reducing risk of severe harm or death in the short term".

* 37. Physical Security (continued...)

	Very Helpful (6%)	Somewhat Helpful (53%)	Neither Helpful nor Unhelpful (24%) X	Somewhat Unhelpful (12%)	Very Unhelpful (6%)
Room searches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"A room search is often experienced as an intrusion (particularly by people who are feeling paranoid, or those who ARE hiding things: searching can be helpful to check for secreted objects and essential if medication is being stored (etc); it is unlikely to directly impact on the urge to self-harm in itself".

* 38. Physical Security (continued...)

	Very Helpful (6%)	Somewhat Helpful (71%) X	Neither Helpful nor Unhelpful (24%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
Use of de-escalation suite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 39. Physical Security (continued...)

	Very Helpful (0%)	Somewhat Helpful (18%)	Neither Helpful nor Unhelpful (53%) X	Somewhat Unhelpful (29%)	Very Unhelpful (0%)
Restriction of access to ward leave	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 40. Physical Security (continued...)

	Very Helpful (6%) X	Somewhat Helpful (47%)	Neither Helpful nor Unhelpful (35%)	Somewhat Unhelpful (12%)	Very Unhelpful (0%)
Use of safe rooms (e.g. empty bedroom, rather than client accessing own room)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"Balance needed between providing a safe environment and limiting further incidents of self harm (different to punitive approaches) and creating a therapeutic environment conducive to recovery. Staff teams often struggle with this".

* 41. Physical Security (continued...)

	Very Helpful (18%) X	Somewhat Helpful (47%)	Neither Helpful nor Unhelpful (18%)	Somewhat Unhelpful (18%)	Very Unhelpful (0%)
Implement/ Increase staff observation of client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"Increase in staff observation can be a double-edged sword if the person becomes agitated by the staff presence. It is helpful if it sends a message that other people care about the individual enough to support them; it can be unhelpful relationally if it draws other people's attention to the self-harm or to the harmer as a figure of jealousy for absorbing staff time and resources".

* 42. Physical Security (continued...)

	Very Helpful (0%)	Somewhat Helpful (24%) X	Neither Helpful nor Unhelpful (24%)	Somewhat Unhelpful (41%)	Very Unhelpful (12%)
Use of seclusion area	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

43. Comments:



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

* 44. Of the list below, please indicate how helpful you consider the following strategies are in the on going care of a client who self-harms: Relational Security

	Very Helpful (53%) X	Somewhat Helpful (47%)	Neither Helpful nor Unhelpful (0%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
1:1 time offered by ward staff when client reports/ presents as wanting to harm themselves (prior to episode of self-harm)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 45. Relational Security (continued...)

	Very Helpful (35%) X	Somewhat Helpful (47%)	Neither Helpful nor Unhelpful (12%)	Somewhat Unhelpful (0%)	Very Unhelpful (6%)
1:1 time offered by ward staff after client has harmed themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 46. Relational Security (continued...)

	Very Helpful (12%)	Somewhat Helpful (18%) X	Neither Helpful nor Unhelpful (59%)	Somewhat Unhelpful (12%)	Very Unhelpful (0%)
Minimal staff interaction is provided during self- harm episode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"I feel cautious about the minimal staff interaction during the episode idea, as I think this is based on the assumption that there is a causal relationship between self harm and attention-seeking. I think sometimes people need attention because they are distressed; they also self-harm in connection with distress; I think it is unhelpful to imply that self-harm equals attention-seeking as this is not an empathetic formulation from the perspective of the person who is harming; it is a judgement from the perspective of the carer".

* 47. Relational Security (continued...)

	Very Helpful (76%) X	Somewhat Helpful (24%)	Neither Helpful nor Unhelpful (0%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
Staff team receives on going support and supervision around the management of clients who self-harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"Staff need to be aware of their inadvertent reinforcements of self harming behaviour, through education and reflection".

"I was involved in a reflective practice session with a staff team who spoke about their reaction to a man [who was self harming] - everyone had a different idea about why he was doing it; at the time they were silent about their views so it was very helpful to enable them to talk about what they had witnessed, how they felt toward their patient, and what their views about causality were".

* 48. Relational Security (continued...)

	Very Helpful (35%) X	Somewhat Helpful (47%)	Neither Helpful nor Unhelpful (18%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
1:1 time provided specifically with client's Primary Nurse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 49. Relational Security (continued...)

	Very Helpful (35%) X	Somewhat Helpful (53%)	Neither Helpful nor Unhelpful (12%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
Providing or encouraging attendance of client reflective groups/ peer support groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 50. Relational Security (continued...)

	Very Helpful (24%) X	Somewhat Helpful (35%)	Neither Helpful nor Unhelpful (35%)	Somewhat Unhelpful (6%)	Very Unhelpful (0%)
Provision of harm minimisation strategies (e.g. holding ice cubes, 'theatre blood', etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

51. Comments:



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

* 52. Of the list below, please indicate how helpful you consider the following strategies are in the on going care of a client who self-harms: Procedural Security

	Very Helpful (0%)	Somewhat Helpful (24%) X	Neither Helpful nor Unhelpful (47%)	Somewhat Unhelpful (24%)	Very Unhelpful (6%)
Transfer client to general hospital/ accident and emergency department	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"The latter would only happen in high security if we could not dress the wounds; such transfers can be very complicated and intersect with risk status - such as sending patients out with 5 staff and handcuffs; have to weigh up the costs and benefits of this - only really done in a physical health emergency".

* 53. Procedural Security (continued...)

	Very Helpful (29%) X	Somewhat Helpful (71%)	Neither Helpful nor Unhelpful (0%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
Review of client risk assessment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 54. Procedural Security (continued...)

	Very Helpful (35%) X	Somewhat Helpful (53%)	Neither Helpful nor Unhelpful (12%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
Review of client care (e.g. consider referrals that may be required such as Autism assessment, anger management work, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 55. Procedural Security (continued...)

	Very Helpful (0%)	Somewhat Helpful (29%) X	Neither Helpful nor Unhelpful (47%)	Somewhat Unhelpful (18%)	Very Unhelpful (6%)
Review medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"Once again, these can always be helpful or unhelpful depending on when, why, and how. I've scored medication lower as, in my experience, changing medication is used to avoid or instead of talking about the emotional and psychological processes and shutting down dialogue. If this were not the case in some instances I think it could be helpful".

* 56. Procedural Security (continued...)

	Very Helpful (47%) X	Somewhat Helpful (47%)	Neither Helpful nor Unhelpful (6%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
Implement contingency plan for client regarding self-harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

"The difference for me as to whether it is helpful or not helpful is if the plan is collaborative. If the client feels 'done to' in my experience this is easily interpreted into 'being punished' which is often part of the cycle which maintains the behaviour of self harm".

"Definitely planning is key; reviewing helps the team to feel less helpless and to establish one another's responses to harm".

"Obviously there is a point where a client may need medical intervention. However if more medical interventions could be made in 'house' ie suture, IV's, other minor injury interventions... it would save on staffing, drama, 'attention', reinforcements that come from being able to get off the ward especially for detained clients with no leave".

* 57. Procedural Security (continued...)

	Very Helpful (47%) X	Somewhat Helpful (29%)	Neither Helpful nor Unhelpful (24%)	Somewhat Unhelpful (0%)	Very Unhelpful (0%)
Assess severity of harm caused, and use this to inform level of staff intervention required	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

58. Comments:



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

Service User Focus Group

A small focus group was run on a low secure forensic inpatient ward to explore the views of service user's on the care and management they have received for their self-harm.

The most significant themes identified from the group were around preferred physical security intervention in response to an incident of self harm, staff member emotional response, wound management and allocated 1:1 time with staff.

* 59. For the statements below, please indicate how much of a priority you feel the following areas are in your experience of caring for people who self harm.

	High Priority (35%) X	Somewhat High Priority (41%)	Neither High nor Low Priority (24%)	Somewhat Low Priority (0%)	Low Priority (0%)
If possible, managing self harm wounds in client bedroom to avoid other ward residents seeing injuries in communal areas (assuming incident occurred in the client's bedroom)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 60. For the statements below, please indicate how much of a priority you feel the following areas are in your experience of caring for people who self harm.

	High Priority (65%) X	Somewhat High Priority (24%)	Neither High nor Low Priority (12%)	Somewhat Low Priority (0%)	Low Priority (0%)
Listening to the client's explanation and understanding of their self-harm	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 61. For the statements below, please indicate how much of a priority you feel the following areas are in your experience of caring for people who self harm.

	High Priority (71%) X	Somewhat High Priority (29%)	Neither High nor Low Priority (0%)	Somewhat Low Priority (0%)	Low Priority (0%)
Maintaining a non-judgemental approach to clients who have harmed themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 62. For the statements below, please indicate how much of a priority you feel the following areas are in your experience of caring for people who self harm.

	High Priority (71%) X	Somewhat High Priority (29%)	Neither High nor Low Priority (0%)	Somewhat Low Priority (0%)	Low Priority (0%)
Maintaining an empathetic approach to clients who have harmed themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 63. For the statements below, please indicate how much of a priority you feel the following areas are in your experience of caring for people who self harm.

	High Priority (18%) X	Somewhat High Priority (71%)	Neither High nor Low Priority (6%)	Somewhat Low Priority (6%)	Low Priority (0%)
Ensuring support is offered to clients when they have been removed from their bedrooms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 64. For the statements below, please indicate how much of a priority you feel the following areas are in your experience of caring for people who self harm.

	High Priority (76%) X	Somewhat High Priority (24%)	Neither High nor Low Priority (6%)	Somewhat Low Priority (0%)	Low Priority (0%)
Being aware of the individual risk and care plans for clients who self-harm, and the individual reasons for which a client may harm themselves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 65. For the statements below, please indicate how much of a priority you feel the following areas are in your experience of caring for people who self harm.

	High Priority (29%) X	Somewhat High Priority (59%)	Neither High nor Low Priority (6%)	Somewhat Low Priority (6%)	Low Priority (0%)
Where possible, to make a client's bedroom safe, rather than moving them to a safe room or seclusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Salomons Centre for Applied Psychology

Management of Self Harm: Final Survey (006)

End of Survey

Thank you so much for completing third and final round of the Delphi Consultation, your time is very much appreciated, and I hope you have found the process interesting to participate in.

This now ends your participation in the Delphi Consultation.

**Many thanks,
Samantha**

67. If you would like to receive a brief report on the final findings of the study, please enter your email address below.

Appendix : Example selection of themes for current practices- Round One (Q9)

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Appendix N. Study Feedback for Delphi Participants

Thank you for participating in the Delphi Consultation to explore how self-harm is managed in UK forensic wards.

Aim

The study aimed to assess whether consensus could be reached between ward staff as to what approaches were most helpful in managing clients who self-harm and how frequently these approaches were used in their practice.

The study also aimed to explore if consensus could be reached as to how the act of self-harm is understood by ward staff.

The psychological models and approaches used by psychologists on the wards to work with clients who self-harm were also identified, and panellists were asked to describe why such approaches were helpful specifically for clients who self-harm.

Panellists

23 panellists completed the first round of the survey, with 19 completing the second and third rounds. Panellists were included from low, medium and high secure forensic wards and included clinical and forensic psychologists, mental health nurses, psychiatrists, occupational therapists and general nurses.

Results

Self-harm management strategies were clustered into three domains; physical (e.g. staff observation, physical restraint etc.), procedural (e.g. updating care plans) and relational (e.g. providing 1:1 time when client is distressed). Physical management approaches were reported as used most frequently, closely followed by relational and then procedural strategies. Panellists were also asked to rate how helpful they found these management strategies. Relational and procedural approaches received high consensus for their helpfulness in managing clients who self-harm. Interestingly, although physical methods were reported as used most frequently, consensus was achieved amongst panellists that physical restraint and use of seclusion *were not* helpful in managing incidents of self-harm.

Staff understanding of why clients self-harm was clustered into four domains: 'Eliciting a staff response', 'self-management', 'diagnostic and iatrogenic factors' and 'meaning of the act'. High consensus of agreement was achieved across the statements for 'meaning of the act', which included statements such as 'clients self-harm as a means to communicate their inner world' or because of 'experiences of complex trauma', showing panellists were in agreement that these are reasons underpinning self-harm for the clients they work with.

Unlike in some previous studies, statements explaining self-harm as an act to 'manipulate staff and gain attention' or 'avoid transfer to prison' showed consensus of disagreement, meaning that panellists did not consider these statements to explain why clients self-harm.

Psychologists within the Delphi survey were asked to describe the models and approaches they with clients who self-harm, and why they consider these models useful for this client group. Models and approaches most often used appeared to be 'focus on therapeutic relationship', CBT, Narrative Therapy, Mentalization based Therapy and Mindfulness. Other models listed included DBT, Compassion Focused Therapy, Schema Therapy, EMDR and trauma focused work.

The reasons for the use of these models for clients who self-harm were explored, and 5 common themes across the models were identified;

- i. Emphasis on Client Emotions
- ii. Developing New Skills
- iii. Positive focus of approach
- iv. Practical Strengths of approach
- v. Emphasis on relational working

I would like to thank you again for your time and support on this project. If you have any further enquiries about the study, please contact me on s.cole784@canterbury.ac.uk.

Many thanks,

Samantha

Appendix O. End of study notification to R&D

End of Study Notification

Study title: The management of self-harm in forensic wards: A Delphi Method Delphi Method.

REC reference: 16/LO/0067

IRAS project ID: 171416

Study Aims:

- 1) To investigate methods used by staff on secure wards for managing self-harm, and explore areas of consensus regarding the usefulness of these strategies
- 2) To explore areas of consensus and divergence regarding how staff understand the reasons for which clients within forensic units might self-harm
- 3) To explore what psychological models and approaches are used specifically by psychologists within secure wards, and why these are considered useful for working with clients who self-harm

Methodology:

A Delphi Consultation methodology was adopted, using three rounds of an online survey sent to staff in secure forensic services. Round one of the survey was used to explore open ended questions regarding how self-harm is managed by study participants. A thematic analysis of this data was conducted to shape the second round of the survey.

This survey explored what methods staff used to manage self-harm, how frequently they use these methods, and how helpful they consider these practices to be.

Participants were presented with statements outlining management strategies and were asked to rate on a likert scale how frequently they used these practices (1= very often, 5= very rarely) and how helpful they considered them to be (1= very helpful, 5= very unhelpful).

The survey additionally explored staff understanding of the reasons for self-harm, and included a series of statements providing various explanations for why an individual might self-harm (1=Strongly agree, 5= Strongly disagree).

A selection of statements taken from a focus group with service users from a low secure forensic wards were also included for staff to comment on the degree to which these practices were felt to be a priority in their work (1= high priority, 5= low priority).

Individual and group responses to round 2 were collated, and all participants received the same survey as round 2, however group responses were indicated, and participants were invited to re-consider their answers in light of these.

Analysis of round three of the survey aimed to highlight areas of consensus amongst participants. Consensus was achieved when over 51% percent of the total responses fell into 'strongly agree or somewhat agree' or 'strongly disagree or disagree'.

Participants

23 participants completed the first round of the survey, 19 completed round 2 and 17 completed round three. Participants included in the study worked across low, medium and high secure forensic units.

Results**Strategies used to Manage Self-Harm**

Strategies listed by participants for managing self-harm were clustered into 3 domains; relational, procedural and physical. Relational strategies included practices such as providing 1:1 time, having staff supervision, providing time with primary nurse. Physical measures included physical restraint, use of staff observation and use of seclusion rooms. Procedural measures involved reviewing client care plan, reviewing medication, and implementing contingency management plans. Staff reported using physical measures most often to manage clients who self-harm, closely followed by relational then procedural strategies.

Helpfulness of Strategies

Relational strategies showed high levels of consensus of agreement for their usefulness in managing incidents of self-harm. No high consensus of agreement was reached for the helpfulness of physical strategies overall, and participants indicated consensus of disagreement for the helpfulness of physical restraint. Participants also indicated consensus that they did not consider use of seclusion areas helpful in managing self-harm. Relational strategies reached consensus of agreement of helpfulness across all strategies, with practices such as teams receiving supervision and providing the client with 1:1 time reaching 100 percent agreement consensus.

Staff Understanding of Self-Harm

High consensus of agreement was reached across statements which explained self-harm as due to the need to communicate distressing emotions, to control distressing feelings, as a response to complex trauma, as an act of internalised anger, to escape emotional numbness and to distract from emotional pain. Consensus could not be reached for statements explaining self-harm as a client's wish to end their life or to 'de-sexualise' their bodies in response to previous abuse. Statements stating that self-harm was an act to manipulate staff or avoid transfer to prison, showed consensus of disagreement, meaning that participants did not consider these to be factors which underpin why a client self-harms.

Psychological Models Used

Delphi participants who were psychologists were asked to list the psychological models and approaches they use in their work with clients who self-harm. Fourteen models were identified, with CBT, Narrative Therapy, Mentalization based therapy, Mindfulness and emphasis on therapeutic relationship being the most frequently commented on approaches. Overall, elements such as 'emphasis on client emotion', 'developing new skills', 'positive focus of approach' 'practical strength' and 'emphasis on relational working' were the factors of the above models which participants felt were most useful when working with clients who self-harm.

Appendix P: Submission information for Journal of Mental Health

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read them and follow the instructions as closely as possible.



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Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In

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